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PASTORAL CARE OF THE HOSPITALIZED CHILD
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A Dissertation
Presented to
the Faculty of the
School of Theology at Claremont

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Religion

by
James E. Kilgore
June 1967

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JAMES E. KILGORE

*under the direction of his Faculty Committee,
and approved by its members, has been presented
to and accepted by the Faculty of the School of
Theology at Claremont in partial fulfillment of the
requirements for the degree of*

DOCTOR OF RELIGION

Faculty Committee

F. Thomas Trotter

Frank H. Timper

Paul C. Verheyde

Date April 12, 1967

F. Thomas Trotter

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CHAPTER I

INTRODUCTION

Purpose. The purpose of this dissertation is to explore the nature of the relationship of the pastor to the hospitalized child and his family. It is assumed that the pastor is a valuable member of the healing team who provides for the child and his family a significant ministry in connection with hospitalization. In this ministry the pastor will be faced with his own needs, feelings, and patterns of interaction with people. It is further assumed that from these experiences he may gain in both understanding and technique which will improve his total ministry.

Methodology. The writing of this dissertation drew its impetus from the clinical pastoral training experience at the Long Beach Memorial Hospital in Long Beach, California. The writer chose to specialize in pediatric ministry and spent much of the summer in close contact with children and their parents.¹ The methodology is to examine the clinical experience which is reflected in the verbatim

¹This writer's initial experience in significant pediatric ministry involved the baptism and death of an infant on the second day of the clinical training experience. The particular case will be discussed in a later chapter.

reports of contacts with hospitalized children and their parents. Research work in the sources available and the writer's experiences with his three children completed the reflective process. Much of this reflection took form under the focus of courses in the field of pastoral care, seminars of various ministerial groups, and conversations with chaplains, nurses, and doctors.

Review of the sources. The writer has checked the available libraries for books, professional articles, and pamphlets relating to pastoral care of the hospitalized child. Only two specific articles dealing with the subject were found.² To this writer's knowledge there is no book published which specifically deals with this ministry. The works of Russell Dicks³ and Richard Young⁴ among others deal with ministry with children as a part of the total approach to the pastor's hospital ministry. The writer has searched the medical, family, pastoral counseling, and religious education journals for further help. The lists of doctoral abstracts gave no indication of any previous

²Douglas G. Cater, "Some Observations Concerning Religious Ministry to Institutionalized Physically Handicapped Children," Journal of Pastoral Care, XVII (1963), 85-92; and Stuart McIntyre Finch, "Pastor's Role with the Anxious Child," Pastoral Psychology, V (1951), 23.

³Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick (New York: Macmillan, 1953).

⁴Richard K. Young, The Pastor's Hospital Ministry (Nashville: Broadman Press, 1954).

work in this area of concentration. It was, therefore, concluded by the writer that the topic was one in which very little work had been done and that it would be suitable for research and writing.

Scope. The writer will examine the needs of the hospitalized child in the categories of emotional development which have been most succinctly stated by Erik H. Erikson in Childhood and Society.⁵ Special attention will be given to the retarded child, the physically handicapped child, the child facing surgery, the anxious child, the emotionally disturbed child, and the critically ill or dying child. An examination of the needs of the child's family will be made in terms of Virginia Satir's insights into the nature of a family as a unit.⁶ The interpersonal relationships of the parents, siblings, and other significant persons make up this nuclear family or unit. The death of the child and the grief ministry with a family will also be seen in this context.

The pastor, through the hospital ministry with children, may become aware of his own need for self understanding. His own childhood experiences, his inner child (in

⁵Erik H. Erikson, Childhood and Society (New York: Norton, 1950).

⁶Virginia Satir, Conjoint Family Therapy (Palo Alto, Calif.: Science and Behaviour Books, 1964).

terms of Eric Berne's formulation⁷), his feelings about hospitalization and death, his relation to his own children, and his general ability to relate to children will be examined.

Definitions. Only four definitions seem necessary as an introduction to this paper. The word child will be used in terms of the first five of Erikson's eight stages of man including infancy, early childhood, play age, school age, and adolescence.⁸ The word therapy will be used in the sense defined by Clark E. Moustakas, drawing on the original Greek noun meaning servant and a verb meaning "to wait."⁹ "Pastoral therapy" will be used in the sense that the pastor "waits" on the child by making himself and his resources available to the child during the period of his hospitalization.

The word hospital refers to an institution which may or may not have a special pediatric department but which houses general, mental or pediatric patients for the purpose of closer observation and treatment under the care of a physician.

⁷Eric Berne, Transactional Analysis in Psychotherapy (New York: Grove Press, 1961).

⁸Erikson, op. cit., p. 219ff.

⁹Clark E. Moustakas, Psychotherapy With Children (New York: Harper and Bros., 1959), p. 2.

The word pastor is understood to mean a Protestant clergyman who is engaged in parish work. The word chaplain will be used to distinguish the clergyman who is a professional or clinical trainee in the field of hospital ministry apart from the parish circle. Any other words which must be clarified will be defined within the text.

Limitations. Because the writer is limited to a single quarter of clinical training in only one center, this work will necessarily be limited to those clinical references. This limited clinical experience also requires the writer to depend more heavily upon the use of secondary sources to support various statements and theories set forth.

CHAPTER II

THE MINISTRY WITH THE HOSPITALIZED CHILD

An introductory overview of the pastoral care of the hospitalized child includes at least four basic considerations: preparation for the pediatric ministry, the goals of the pastor, the resources of this work, and the principles on which this ministry is established.

I. PREPARATION FOR PEDIATRIC MINISTRY

The preparation of the pastor for his ministry with the child in the hospital is not altogether different in character from that of other helping professions. The fundamental understandings of the student in psychiatry, psychology, or pediatrics, seem to this writer, to be necessary to the preparation of the seminarian as well. As an illustration of this, one can cite the work of Dr. Helen Witmer in Pediatrics and the Emotional Needs of Children. She lists eight objectives of psychiatric instruction for the undergraduate medical program:

1. To teach fundamental concepts of human behavior, i.e., motivation, gratification and conflict.
2. To teach the emotional experiences of sick people and their relatives. The student should also be made aware of his own emotional relationship to his patient.
3. To teach that emotional disturbances as well as toxic, metabolic, or physical factors produce illness.

4. To teach an understanding of illness associated with or caused by disturbed cerebral metabolism.
5. To teach some classificatory knowledge of psychiatric syndromes.
6. To teach useful diagnostic and interviewing techniques.
7. To assist the student in gaining insight into his own personality make-up--particularly his emotional biases, prejudices, and blind spots--preferable through intimate contact with the psychiatric teacher.
8. To give a reasonable concept of methods of psychotherapy and an appreciation of his own potentialities and limitation in this regard.¹

A fuller treatment of these principles will be developed in the later chapters of the paper. The fundamental concepts of human behavior are basic both to the pastor's understanding of himself and his ability to relate to children. A basic criticism may be levelled at much of our seminary training at this point. Much like the adult-oriented point of view in the New Testament, preparation for the parish ministry is a basic concentration on adults. The Bible is an adult book, essentially written about adult experiences and its theology is an adult theology.

To this writer's knowledge, there is not a course in the seminaries of our denomination in the field of counseling with children. The departments of education offer courses in teaching children, but the basic framework of this paper is in the field of pastoral counseling. Can one

¹Helen Witmer, Editor, Pediatrics and the Emotional Needs of Children (Cambridge: Harvard University Press, 1948), p. 91.

assume that every seminary graduate who has a course in pastoral counseling will be able to minister effectively with the hospitalized child? The obvious answer is no. Certainly the exceptional seminary student will with research and experience, be able to adapt himself to this ministry. The writer's concern, however, is whether this is an area where the seminary curriculum should be adjusted.

At present in the United States we add to our population over three million people per year, a number almost sufficient to make a city the size of Chicago.² These statistics are based on a report by William R. Leonard, director of the statistical office of the United Nations (June, 1961). A simple bit of arithmetic will allow one to see that in fifteen years there would be forty-five million children fifteen years of age and under. This increasing number of children requires that the seminary take seriously the place of the child in society, and more adequately prepare men for ministry with children. One of the ways the preparation of the pastor for pediatric ministry could be improved would be to require at least one quarter of clinical experience or hospital training in the general hospital setting in which the students looking toward the parish ministry would have the opportunity to develop an

²Elizabeth Dwight McMaster, The World's Exploding Population (Kennebunk, Me.: Star Print Co., 1961), p. 7.

awareness of the needs of the hospitalized child. The supervision of specialists in the medical field would give perspective to the student's preparation and increase his knowledge of the physical factors involved in the hospitalization of children. A sensitive pastoral supervisor would have the opportunity to deal with the religious and theological insights and resources with which the student would need to become familiar during this period of training.

A second way of improving pastoral preparation for ministry to the hospitalized child would be a period of observation and study of child development in a nursery school, as suggested in the article by Jack Westman which is discussed in Chapter 3.³ In becoming familiar with the healthy child and his reaction in the nursery school setting, one is able to recognize more easily the deviations and emotional needs in the hospitalized patient.

A third suggestion based on this research is that the pastor's training should include more exposure to the church school experiences of the children in a parish. This exposure would provide him with another channel through which to familiarize himself with children and to maintain his interest and sensitivity toward the children in the local parish ministry.

³Jack C. Westman, "Nursery School: Outpost for Preventive Psychiatry," Archives of General Psychiatry (January 1964), 31-35.

This preparation is not solely the responsibility of the seminary however, for no theological institution can provide a "total" preparation for any parish minister. The desire to be an adequate therapeutic and pastoral person and to make the resources of the Christian faith available to children will be his greatest stimulus for further preparation for ministry both with the healthy and the hospitalized child.

2. GOALS OF THE PASTOR

Based on the available literature and the clinical experience of the writer, there are four goals of pastoral ministry with the hospitalized child. They are: one, to be aware of the needs of the patient; two, to be aware of the needs and the relationship of the family to the patient; three, to be aware of one's own needs in the process of hospital ministry; and four, to participate effectively as a member of the healing team with the hospitalized child. Three later chapters will deal with goals one, two, and three of this list. Our specific attention here is on goal four.

How does the pastor participate effectively as a part of the healing team in the care of the hospitalized child? He participates first as a warm accepting human being. The initial ingredient in the healing of the child is the supportive assurance that he is not alone in his

suffering. The pastor empathizes with the child and shares his feelings, communicating this to the child by listening and reflecting in such a way that the child comprehends the pastor's understanding. Granger Westberg lists three methods of communicating understanding: listen intelligently, try to sense the patient's feelings, and reflect what you think the patient says.⁴ Another suggestion for communicating warmth and acceptance to the hospitalized child is made by Carl J. Scherzer. He points out that the pastor should talk directly to the child, not through the parents to the child. He also notes small gifts are greatly appreciated by the hospitalized child.⁵ These gifts further illustrate the direct concern of the pastor for the child.

The healing quality of pastoral care is in sensing and responding to the child's needs and feelings. Understanding the words the child speaks is not sufficient; any visitor may have a conversation with the patient. The child is seeking a bridge from the isolation of suffering or the fear of surgery. The pastor who effectively communicates to the child that he senses the fear or pain or

⁴Granger Westberg, Nurse, Pastor, and Patient (Rock Island, Ill.: Augustana Press, 1965), p. 23.

⁵Carl J. Scherzer, Ministering to the Physically Sick (Englewood Cliffs, N.J.: Prentice-Hall, 1963), p. 77.

whatever the child is attempting to communicate has begun to share in the healing process. The ability to reflect to the child his own feelings and to communicate understanding beyond the words the child has spoken is the necessary ingredient in his assurance of acceptance, despite his fear or pain.

The authority for the pastoral visit lies in three concepts: the patient's needs, the pastor's understanding of those needs, and the pastor's ability to minister to those needs.⁶ Ministry to the patient allows the pastor to move one step beyond a warm and accepting relationship into a helping and therapeutic one; he participates concretely in the healing process.

Historically, this pastoral function has been called "the cure of souls." John T. MacNeill has written a volume entitled The History of the Cure of Souls⁷ and W. A. Clebsch and Charles R. Jaekle have a volume entitled Pastoral Care in Historical Perspective. In the latter we read:

The ministry of the cure of souls, or pastoral care consists of healing acts done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and

⁶Richard C. Cabot and Russell L. Dicks, The Art of Ministering to the Sick (New York: Macmillan, 1953), p. 12.

⁷John T. MacNeill, The History of the Cure of Souls (New York: Harper and Bros., 1951).

ultimate concerns.⁸

Four functions are mentioned in this statement on the cure of souls: healing, sustaining, guiding, and reconciling. The pastor is called upon to use the resources of the Christian faith--scripture, prayer, sacraments, and any other helpful aids to faith. These resources literally become the "tools" of pastoral care.

There are numerous references in pastoral counseling journals to the misuse of our theological resources and symbols, but there is a growing awareness of the need to revitalize them.⁹ Through the use of the Bible, prayer, the sacraments, and devotional literature, the pastor may assist in the healing process, particularly in the lengthy hospitalization. We cannot clinically separate faith from personality in the child or the adult. Sustaining the spiritual life in the hospital may be vital to the healing process; the writer believes it is. The careful and sensitive pastor may guide the older child to use the insights he gains from the stay in the hospital to deepen his experience in the spiritual dimension. The deepening spiritual dimension is associated in many incidences with the deepening relationship of the child with the pastor.

⁸W. A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, N.J.: Prentice-Hall, 1964), p. 4.

⁹Seward Hiltner, "The Integrity of Pastoral Care," Pastoral Psychology (November 1966), 17-26.

When the relationship is therapeutic, the pastor is essentially doing "relationship therapy" with the child.

Clark E. Moustakas says, "Relationship therapy is a unique growth experience created by one person's seeking and needing help and another person who accepts the responsibility of offering it."¹⁰ The pastor is a therapist, for good or for ill. He has no real choice as to whether or not he will relate to people, but he does have the choice as to how he will relate to them. Ross L. Mooney says, "Therapy is only an identification of what all men require for their existence and fulfillment as members of the human species."¹¹ Moustakas adds, "The most important aspect of therapy for the normal child is a concentrated relationship with the therapist."¹²

It seems to this writer that the relationship which Mooney and Moustakas describe is the same as the function Clebsch and Jaekle identify as pastoral when done by "a representative Christian person." Different resources may distinguish this form of therapy from another, but the goals seem to be essentially the same. Pastoral therapy is

¹⁰Clark E. Moustakas, Psychotherapy with Children (New York: Harper and Bros., 1959), p. 1.

¹¹Ross L. Mooney in the Foreword to Ibid.

¹²Ibid., p. 43.

different from other forms of therapy because the resources involved are religious, and the pastor's approach is in a theological, as well as an existential and psychological, framework. This is why it must be emphasized that the pastor is a part and not the whole of the healing team. The place of the physician, the nurse, the play therapist, the psychiatrist, the art therapist, and any other significant persons sharing in the healing of the child must be respected by the pastor. The aims of the varying helping professions will complement the work of the pastor, and his work will complement their contributions.

The goal of the pastor is to be understood in a broad scope. Daniel D. Williams in The Minister and the Care of Souls says, "To bring salvation to the human spirit is the goal of all Christian ministry and pastoral care . . . salvation is itself a kind of healing."¹³ The writer finds this definition by Williams to be essentially in agreement with the kind of complementary role which the pastor plays as a part of the healing team with the child. The pastor's concern is for the total person as a child of God. He is concerned with the living relationships of the child.

¹³Daniel D. Williams, The Minister and the Care of Souls (New York: Harper and Bros., 1961), p. 11.

One is aware, however, that this position is not unanimous. There are pastors whose concerns are more restricted who share in the healing ministry. One example is the work of Peder Olsen, who says that psychotherapy means "treatment of the soul life."¹⁴ Maintaining that psychology is no "substitute" for the gospel, Olsen adds these further comments:

But the eternal salvation of man is for soul care far more important and decisive than achieving health. . . . For psychotherapy, psychic soundness is the greatest, but for soul care truth is greater than soundness.¹⁵

If Olsen means that in some way the pastor "saves souls" that are distinguished from bodies, then this writer finds his definition of pastoral care too limited. It is not sufficient to say that truth is greater than soundness, although the statement may be factual. If the pastor is to function as a member of the healing team, his concern is more than simply to communicate knowledge about death and life after death. He is involved with the living relationship and the existential realities which the patient fears. He seeks to heal, sustain, guide, and reconcile. This task, however, is greater than the verbal acknowledgment or communication of truth; the pastor's goal is inadequate if

¹⁴Peder Olsen, Pastoral Care and Psychotherapy (Minneapolis: Augsburg, 1961), p. 6.

¹⁵Ibid., pp. 43-44.

it does not include an awareness of the needs of the patient, the family, his own needs, and the integration of these factors into a relationship which promotes healing in the patient and the family. How the pastor promotes this relationship is to be our concern in the final two sections of this chapter dealing with resources and principles.

3. RESOURCES IN THIS MINISTRY

The resources available to the pastor in the hospital and within the context of this ministry may be as limited or varied as the pastor's creativity and use of helpful persons and groups.

1. The physician. As a part of the healing team working with the hospitalized child and his family, the pastor will want to establish rapport with the other members of the healing team. First to be considered is the child's physician. The cause of the hospitalization, the physical strength of the child, the concerns the child has shared with him, and the effect of the prescribed medication on the child's mental and emotional reactions will be the kinds of information the doctor may share with the pastor. It is the writer's experience that many doctors are willing to share this information with a pastor who accepts his place as a part of the team working with the child. The interchange between the pastor and the doctor

may be a significant experience for both of them. The child will receive the benefits of the physician's medical knowledge and the spiritual resources which the pastor may make available to him. The doctor's understanding of the child may be increased in his conversation with the pastor, and the pastor will undoubtedly be guided and helped in his ministry with the child through his discussion with the doctor. The temptation to become a medical adviser will be as great for the pastor as the temptation is for the doctor to ignore the role of spiritual resources and emotional causes in the healing process. Their interaction with each other may not only give greater understanding and cooperation between them, but may also help the child to learn a valuable lesson about the integration of the physical and spiritual in life.

2. The medical library. The medical library of the hospital will be of value to the pastor in obtaining factual information about the child's illness or surgery. Current journals and other reference tools may give him broader insights into the healing process in general and the place of pediatrics in particular. A teaching hospital--that is, one which is not only serving the needs of patients but is also training doctors, nurses, and other medical personnel--will probably have a better equipped library and reference materials than a hospital

which does not engage in the teaching function. This is not always the case. The Pomona Valley Community Hospital, for example, though not a teaching hospital, has a medical library which is adequate and is available to local pastors through the office of the assistant administrator of the hospital. The pastor will learn of the various resources in a medical library only by taking the time to become familiarized with the physical hospital setting, to locate the library, and to determine what resources are available to him and how he might use them.

3. Administration. The administration of the hospital is an involved and complicated system. The family may find that questions arise concerning the services or expenses of the hospital. The pastor may be asked for advice or information about these things. If he understands the workings of the hospital and something of its organization, he will be able to refer the parents to the right channel for information. Many hospitals today employ a person known as a "patient representative" whose function is to visit with patients and answer questions regarding the services of the hospital. The pastor should not become involved in defending the hospital or criticizing it on behalf of the parents. He may encourage the parents to ask for more information if they are dissatisfied with the services or he may suggest to the doctor, nurse, or administrator that they discuss the matter with the parents,

assuming he has obtained permission of the parents to do this.

4. The pediatric nurse. Granger Westberg in his book, Nurse, Pastor, and Patient, suggests that the nurse may be one of the most important persons in the life of a patient. In fact, his definition of the role of nursing is so great in its scope that a nurse fulfilling the outline in his book might very well have a pastoral relationship to the patient.¹⁶ The concern of this chapter, however, is that the nurse and the pastor complement the work that the other members of the healing team are doing. In conversation with a number of nurses during the clinical experience, the writer made two observations concerning pediatric nurses. One is that they seem to have a great deal of identification with children. Many of the nurses who specialize in pediatrics seem to find much creative satisfaction involved in this work. They fill emotional needs in their own lives as "mothering ones." The second observation is related. The nurses seem to be able to give a great deal of themselves emotionally to patients. She is constantly busy with the details of the floor and has little time to spend in personal contact with particular patients. Conversational time is accessible to the nurse's aide more than to the nurse. However, the nurse's ability

¹⁶Westberg, op. cit., p. 23ff.

to be patient with children and to give a great deal of herself may be as essential as conversational time. The nurse often has the opportunity to sense the loneliness of the child in his request for certain kinds of treatment or in the comments he makes when she is with him. She also observes the numbers and types of visitors who come to the hospital to see the child. She may make observations on her own about the emotional climate in the home and the relationship of the children and the parents. As the pastor is willing to listen to the nurse and to gain insights and helpful information from her, he will find her to be a valuable resource in his ministry with children.¹⁷

5. The play therapist. Although not all hospitals employ such a person, an important resource to the pastor may be the play therapist. The skilled play therapist is one of the most important assets in a pediatric setting. His contribution through the use of toys, games, and crafts may be a very significant part of the child's healing. Where no play therapist is available, particularly in his ministry to a child in what Erikson called the play age, the pastor may find that acquiring some skills in the

¹⁷It can be noted at this point that very little research has been done in the area of pastoral ministry with the staff of the hospital. The writer's experience in clinical training led him to believe that there are many valuable lessons to be learned when these areas of ministry are explored.

principles of play therapy will increase his ability to minister to these children.

6. The Art therapist. Edith Kramer says of art therapy:

The basic aim of the art therapist is to make available to disturbed persons the pleasures and satisfactions which creative work can give, and by his insight and therapeutic skills to make such experiences meaningful and valuable to the total personality.¹⁸

The art therapist may work in conjunction with the pastor; and the work that both of them do, as an example of this complementary functioning, will contribute to the healing of the patient.

These are the resources of the medical community, but the pastor will need to be familiar with, and able to use, other resources as well. In other sections the writer will discuss the supportive relationship of the parents and the sibling children. Family resources are extremely important, so the pastor's role is to motivate the members of the family in order that they may make themselves more available to the child in the healing process.

7. Groups. The pastor may often be the information link between the school class room, the community clubs or organizations for children, and the church school or religious groups to which the child belongs. Particularly

¹⁸Edith Kramer, Art Therapy in a Children's Community (Springfield, Ill.: Thomas, 1958), p. 5.

in the sustaining ministry of terminal illness or of prolonged periods of rehabilitation and confinement following surgery, a child may be reassured and encouraged by the knowledge that he is missed from groups in which he has been participating. Members of a church school class, for instance, may be allowed to visit the child. The sense of identity and concern from other children may be of invaluable help to the patient. A creative pastor might select several children in his own congregation to be trained for hospital assistance.

Dr. Sherman Little¹⁹ feels that groups may be used effectively in the healing process with children. Though the pastor of a local parish may find this an impractical if not impossible to develop himself, the institutional chaplain may be encouraged to use group techniques with children six or older in the hospital. A ward, sun room, or therapy room present natural opportunities for group work.

8. Religious resources. The resources cited to this point are those the pastor may find helpful in connection with his own ministry to a child. Religious resources are those which the pastor himself uses with the hospitalized child. Religious resources are the Bible, prayer, devotional materials, the sacraments or ordinances, and

¹⁹Sherman Little, "Psychotherapeutic Aspects of Chronic Illness in Children," G. P., XXXI, 4 (April 1965), 134.

other aids to the faith appropriate and of significance to the child and the pastor. Two dangers are obvious. The Bible, prayer, a devotional booklet, or a sacrament may be used as a defense to keep the child at a distance. The performance of a sacrament may tend to fulfill a pastor's need more than the patient's. Hence, his own feelings about the use of religious resources need to be carefully evaluated in relation to each patient.

Later in the paper, the writer will make reference in case materials to the use of prayer with patients. Prayer should be brief, carefully planned in advance, or even written out and left with the child at the close of the call. Prayer should include the patient in its thoughts and method of address to God. Patients may be prayed for at certain times and in certain specific situations, but prayers are generally more effective when the pastor and the patient share in them. The pastor may prepare a set of prayers, appropriate to the child's needs, to be given to children who are hospitalized. Books of prayers for children and devotional readings are also available. As an example, two companion volumes are called Little Visits with God and More Little Visits with God.²⁰ These particular volumes are helpful because they give lists of

²⁰Allan Hart Jahsmann and Martin P. Simon, Little Visits with God (St. Louis, Mo.: Concordia, 1967), 287 pages and Allan Hart Jahsmann and Martin P. Simon, More Little Visits with God (St. Louis, Mo.: Concordia, 1961), 319 pages.

scriptures and themes in an index which is useful to the pastor in preparing the visit in which he will read scripture and talk about a theme with the child. This is most applicable in an extended illness. There are two hundred prayers for children included in each of these volumes. Of course, the pastor must be careful to evaluate the stage of life at which he finds the child and the appropriateness of the prayer he chooses to use.

The use of scripture with children in the hospital has not been fully explored by the literature known to this writer.²¹ Suggestions which follow, therefore, are based upon his clinical experience, church school exposure, and the relation to his own children. Reading scripture with children under school age may be entertaining to the child, but is not likely to be any more helpful than reading any other story. Ilg and Ames suggest that the child becomes interested in prayer, ritualistic services, and the symbols of the church at age six.²² The gift of a small selection of scripture printed in a booklet may be as meaningful for

²¹Wayne E. Oates has a chapter entitled "The Bible in the Pastoral Care of Children" in his book, The Bible in Pastoral Care (Philadelphia: Westminster Press, 1953) pp. 55-70; but he does not mention illness. The writer did not feel the chapter was relevant at all to this paper. It is the only specific source he located.

²²Frances Ilg and Louise B. Ames, Child Behavior (New York: Harper and Bros., 1955), p. 308.

the pastor's ministry as reading scripture with the child. The child senses the pastor's preparation for the call and his interest in giving the child a gift. The child's ability to read and understand the portion given should be considered by the pastor. Various types of literature of this kind are available from the American Bible Society. One such example is called "Psalms for Strength."²³

The sacraments or ordinances of baptism and communion (the Lord's Supper) may be used in the hospital ministry with children. An example of the place of baptism in the life of the family will be given in Chapter V. The pastor will not generally be asked to make exceptions to the rules of his denomination, except in cases of emergency. He must then decide what values will guide him to these choices. It seems to this writer, however, that the baptism of a child is far more important for the parents than for the life of the infant. Thus, it becomes part of the pastor's family ministry.

From about age six the hospitalized child may be interested in receiving communion during an extended stay at the hospital. The use of the ordinance (sacrament) of the Lord's Supper will depend upon the practice of the

²³A catalogue of all such materials is available by writing to the American Bible Society, 1662 Wilshire Boulevard, Los Angeles, California, 90017.

local church, the preference of the pastor, and the request of children to whom he ministers. The pastor who makes regular rounds to the hospital and who serves communion to the patients of his congregation may find the child will find special significance in this service. It is meaningful to the child first because of the close relationship with the pastor through the personal attention received during the service of communion in a one-to-one relationship. From age six²⁴ most children seem to be able to comprehend and appreciate the rituals of the church. There is a "feeding" aspect to communion which may be significant to the child. The symbolic meaning of the elements of communion may be of greater value to the child as the pastor interprets them. The child may be able to see in the elements of communion which are brought to him in the hospital a symbol of the resources of God's natural creation and the supportive strength of his church and faith.

Dr. Kenneth Appel says of religious resources, "Readings of a religious nature may be of great therapeutic value."²⁵ If adequately written for children, the pastor's

²⁴Op. cit., p. 308.

²⁵Kenneth E. Appel "The Collaboration of the Pastor and the Psychiatrist," in Hans Hoffman, Editor, Making the Ministry Relevant (New York: Charles Scribner's Sons, 1960), p. 84.

use of devotional literature may greatly benefit the patient. Each denominational publishing house has certain pieces of literature available for the use with hospitalized patients. Some of this material is specifically designed for children.²⁶ This is an area where some research and publication could well be done on an ecumenical as well as a denominational basis. Materials written within the framework of Erikson's stages and bringing to bear the experiences of the church school, would be a valuable asset for the pastor. It is this writer's experience that often a note pad simply headed "from the desk of the pastor" is a significant piece of religious literature if the pastor will use it as such. Rather than using a printed prayer or scripture card, one may copy a verse of scripture and write a prayer appropriate to the patient, using the patient's name, and give it to the child. This is a personal and yet religiously-significant resource for the child to continue to use after the visit is concluded. It also serves as a note to be left when the pastor finds the child in X-ray, physical therapy, or in some other treatment room of the hospital, and a visit cannot be made. This approach is one which is satisfactory to the writer. The pastor should

²⁶Samples may be obtained from Comfort and Strength, 1720 Chouteau Avenue, St. Louis 3, Missouri.

always read and evaluate pices of literature before giving it to a patient,

9. The hospital chaplain. There are a growing number of hospitals, such as the Memorial Hospital of Long Beach, California, which now have a chaplain or chaplains on duty or on call twenty-four hours a day. The pastor of a parish should include the hospital chaplain in his thinking about the care of the child. Most of these chaplains have had special training in the general and mental hospital setting; many have had some special pediatric experience. The chaplain may be able to help the pastor plan his ministry to the child and may share his insights about the religious needs of children. The pastor and the chaplain may initially visit the child together and alternate visits as they share in the ministry to the child. The pastor will not want to ignore the chaplain's ministry to the child. They must work together as a team.

4. PRINCIPLES OF THIS MINISTRY

Although the basic concern of this paper is the hospitalized child, the principles discussed here are appropriate to ministry with the sick child in his home. In the experience of the writer, a visit from the pastor is seldom requested when the child is sick in his own home, but the seriousness of being hospitalized is a cue for the parents to notify the pastor.

Three kinds of principles need to be noted: theological, phenomenological, and practical.

1. Theological. To discuss the theological principles involved in pastoral care with the hospitalized child is in no way a declaration of intention to state a theology of pastoral care. Perhaps these principles might be developed into such a theology, but these are intended by the writer to be the basic steps one initially takes in thinking through the theological background for his ministry with the child in the hospital. Each principle is based on a doctrine widely accepted in the Christian church.

a. Every person is of worth to God. This statement is for pastoral care an application of the doctrine of the incarnation. God is concerned with his creation and the persons he has made. This is the faith of the pastor as he ministers to the child in the hospital. No child is insignificant, and the pastor's concern for him in visitation relates this basic concept.

b. Honesty is the first step in relationship. The doctrine of repentance is basically a statement of honesty before God. A pastor's awareness of himself allows him to be a transparent person through which another may see himself. Helping the child to accept himself as he is is one of the first steps sought by the pastor in his hospital ministry. It is this step in relationship to the pastor that may prepare the child for the same step toward God.

c. The relationship to God begins with the knowledge that one is accepted by God. This corresponds to the doctrine of redemption. The pastor becomes a redemptive person in relation to the child as he accepts the child and ministers in ways which are described in other sections of the paper.

d. Acceptance by another is the motivation for accepting others. The pastor accepts the child because he himself has experienced what it means to be accepted by God. This is a psychologically-oriented statement of the doctrine of reconciliation. As Christ has reconciled us to God, we seek to reconcile others to him. Being reconciled, the pastor acts as a ministering agent of reconciliation to the child.

For the writer these four basic assumptions are the theological principles guiding his ministry to all persons. Though they are not intended to be restatements of another's position, the two sources most influential in the forming of these principles are Paul Tournier's The Whole Person in a Broken World and Carl Rogers' On Becoming a Person.²⁷

2. Phenomenological. It seems to the writer that there are two phenomenological principles that may be

²⁷Paul Tournier, The Whole Person in a Broken World (New York: Harper & Row, 1964), see particularly chapters 1 and 6, and Carl Rogers, On Becoming a Person (Boston: Houghton Mifflin, 1961), see particularly part 4.

clearly observed in the pastoral ministry to the hospitalized child.

a. The first is that healing takes place in the world through many kinds of efforts. The medical, the psychological, the spiritual, and other forms of healing are present in today's world. The pastor must see himself as one who shares with others in the healing of minds and bodies. The pastor observes these "happenings," and he seeks to understand them more clearly.

b. The second principle is that any living person may be helped. Virginia Satir claims that no individual is beyond help.²⁸ The greatest force the pastor has to offer a patient in this kind of phenomenological observation is for Russell Dicks the "energy of interest."²⁹ The writer observed that cases described as "beyond reach" have, through various relationships, often resulted in progress which had not been predicted. For this reason the pastor operates on the principle that to some extent all persons may be helped.

3. Practical. There are two practical principles which should be mentioned in this section of the paper. First is observation and second is communication.

²⁸Lecture notes, workshop on Conjoint Family Therapy by Virginia Satir, School of Theology, Claremont, California, March 21, 1966.

²⁹Cabot, op. cit., p. 10.

a. Observing may be one of the most useful techniques the pastor has. He simply looks at the setting and reflects on what he sees. As he comes to know the hospital, he will become aware of signs which have particular meaning to the personnel in the hospital. He will come to know areas of the hospital which are restricted for various reasons. The personnel of the hospital will become more familiar to him, and the rules of the employees, whether written or unwritten, will begin to show up. He will also be able to observe the role-expectations of ministers in the hospital through his contacts with the personnel. He may not agree to be molded by those role-expectations, but he should be aware of what they are. The same principle is involved in his relationship to the patient. The pastor will observe signs of attention--the cards, the flowers, candy, toys, gifts which are in the room--which reflect the interest of others. He will also observe the patient's reactions to him. He must recognize the cues to leave and return on another day when the patient is restless in bed, sighs deeply, or the eye contact is lost. Supervised hospital work and training sharpens this ability to observe.

b. Clear communication is essential. Communication in the pastoral ministry with the hospitalized child is twofold: from the patient and to the patient. Much of the

earlier sections has laid emphasis on the listening function of the pastor. He will need to listen in order to communicate to the patient that he is aware of the needs expressed. He will also communicate to the patient by interpretation. He may communicate by confrontation or by silence as well. The one technique which is probably least helpful in the ministry with the child in the hospital is the probing question. The patient is in a defenseless position in the hospital, and the ministry of the pastor will be far more effective if he is supportive and listens rather than is probing in his communication.

CHAPTER III

THE NEEDS OF THE PASTOR

There are two aspects of the needs of the pastor which seem relevant to his ministry to the hospitalized child. First is the pastor's own self understanding. Second is his ability to relate to children.

1. SELF UNDERSTANDING

On the flyleaf of Carl Rogers' book, Client-Centered Therapy, is a quote from Ralph Waldo Emerson:

We mark with light in memory the few interviews we have had, in the dreary years of routine and of sin, with souls that made our souls wiser; that spoke what we thought; that told us what we know; that gave us lead to thee what we inly (only) were.¹

This description of the liberating person may well be an assumption of what a therapist wishes to be. At least for this writer it is a description of the kind of relationship a pastor desires with others. Before he can live up to the high goals and standards which Emerson has set forth, the pastor must understand himself. Self understanding comes before one is able to understand another. The degree to which one understands himself will mark the degree to which he is able to understand another person,

¹Carl Rogers, Client-Centered Therapy (New York: Houghton-Mifflin, 1951).

and his ability to understand and accept his own limitations and problems will be the degree to which he may accept and understand the limitations of another. There are at least four ingredients which go into the development of self understanding as it relates to the pastor's ministry with children. He must have an awareness of his own childhood, of what Eric Berne has called his emotional Child,² of his crisis feelings (those which deal with hospitalization and death), and of his relation to his own children, where applicable.

1. His own childhood. Herbert Butterfield in Christianity and History says:

It is a mistake for writers of history and other teachers to imagine that if they are not Christian they are refraining from committing themselves or working without any doctrine at all, discussing History without presuppositions. Amongst historians, as in other fields, the blindest of all the blind are those who are unable to examine their own presuppositions, and blithely imagine therefore that they do possess any.³

What Butterfield, the historian, claims concerning the writing of history is true for the fields relating to psychotherapy and the ministry. Every psychotherapist operates with some frame of reference. He has presuppositions which are "givens" because of his own experience. It is

²See Eric Berne, Transactional Analysis in Psychotherapy (New York: Grove Press, 1961) or Eric Berne, Games People Play (New York: Grove Press, 1964), p. 29ff.

³Herbert Butterfield, Christianity and History (London: G. Bell, 1949), p. 46.

only the man who is aware of these presuppositions, however, who is able to alter them if the facts demand that he should do so.⁴ "The psychotherapeutic situation is extremely intricate; a complex interaction between two imperfectly known variables--the therapist and the patient," says Anthony Storr.⁵ The pastoral care of the hospitalized child is such a therapeutic situation. As in scientific experiment, the more we can limit one of the variables the better we will be able to recognize the reactions and changes in the other variable. It is essential therefore, that the pastor recognize his own presuppositions, feelings, and background as he faces the ministry with the sick child. How the pastor gains this understanding is not the primary concern of this paper. He may engage the help of a psychiatrist or other therapist for psychoanalysis; he may seek insight through the study of pastoral counseling principles or in the clinical training experience. Some may be perceptive enough honestly analyze their own backgrounds and experiences in sufficient depth to give a working awareness of themselves as persons. A group experience, either with other ministers or with non-professional persons, may also provide a way into self understanding. Or a study of the principles of personality and human

⁴Anthony Storr, The Integrity of the Personality (Baltimore: Penguin Books, 1963), p. 12.

⁵Ibid., p. 11.

development, such as those stated by Erik Erikson, may provide the pastor with insights about himself. But, how ever it is achieved, self understanding on the part of the pastor must precede his most effective ministry with the child or the family.

2. His personality structure. Eric Berne has introduced a method of understanding human personality called structural analysis (see footnote 2). In structural analysis three aspects of the person called "ego states" are seen: the Parent, the Adult, and the Child. Any one of the three aspects, or ego states, may assume the "executive" functions of the person at any time. The Parent fulfills the function of reflective judgment, evaluation, moral standards, and discipline. It allows one to be a real parent and makes many responses automatically. Its function in the personality is in these terms. The Adult, as seen by Berne, is like a computer which measures reactions and determines results and outcomes in an unemotional, scientific way. It records the experiences of the person and provides the information necessary for effectively dealing with the outside world. The Child is the residual core of the individual for intuition, creativity, spontaneous drive, and enjoyment. These are the essentials of Berne's formulation. The reader may gain more details by turning

to Berne's original work, Transactional Analysis in Psychotherapy.⁶

In The Pastor and the Children, Frank and Mildred Eakin report the story of a minister who had a difficult time visiting a particular child in the hospital.⁷ The story given by the Eakins is an example of the necessity of understanding the pastor's own Child in structural analysis. When the pastor finds that he is unable to relate freely to a child, he may find that his own "Parent" is too restrictive. Problems in the pastor's own life may arise when any one of the ego states--Parent, Adult, or Child--is exclusive; the balanced personality is able to use all three as necessary. There are times, however, when each of us needs to be a child. "Becoming a parent not only does not end one's needs to have a parent, but often intensifies it."⁸ The pastor who cannot be a Parent to himself or allow his own Child expression will find it extremely difficult to be a parental figure or a therapeutic individual in relationship to hospitalized children. This fact is so important that E. Van Norman Emery calls

⁶Berne, Transactional Analysis in Psychotherapy.

⁷Mildred Eakin and Frank Eakin, The Pastor and the Children (New York: Macmillan, 1947), p. 18ff.

⁸John C. Glidewell, Editor, Parental Attitudes and Child Behavior (Springfield, Ill.: Thomas, 1961), p. 167.

the capacity to be a good parent to one's self, "the hallmark of maturity."⁹ Keeping the Adult in charge so that he can "program" the parent or the child in relation to the patient will be the pastor's greatest asset in self-understanding and in his ministry to the hospitalized child.

3. His crisis feelings. Another area where the pastor needs to understand himself is in his attitude toward crisis experiences, particularly those relating to hospitalization and death. Margarita K. Bowers in Conflicts of the Clergy claims that an early experience with death is a frequently occurring motivational dynamic among clergymen. "A death experience in childhood tends to bring on a loss of trust in human relationships by the child, causing him to seek magical identification with God and the Christ figure . . ."¹⁰ Dr. Bowers is careful to point out that this indication of professional and vocational influence on a minister is based on her experience with patients, and one cannot conclude that all vocational choices are based on an early death experience. However, the pastor must certainly be aware of his own feelings regarding hospitalization and death, lest he finds himself unavailable to the child or the family in this ministry.

⁹Ibid., p. 168.

¹⁰M. K. Bowers, Conflicts of the Clergy (New York: Thomas Nelson and Sons, 1963), pp. 31 and 34.

The following experience came early in clinical training for the writer, and it demonstrates the lack of ability to ask facilitating questions and help a parent in an anxious moment.

- Ch 2 - (looking to bed) You must have a little one out to surgery this morning.
- Mo 2 - My little girl is having a heart x-ray. She'll be back soon (looking at sleeping child in the other bed).
(I felt that at this point I could have asked a question about whether she feared her child might not come back, but did not.)
- Ch 3 - This little girl had a tonsilectomy yesterday (looking at name tag), I thought she would be going home today. No, I see it's a different child.
- Mo 3 - That child must have gone. This one came in after my daughter did last night.
- Ch 4 - I certainly hope things will go well for . . . (looking at name on bed) Diana, Mrs. D.
- Mo 4 - I hope so too. (sighing)
- Ch 5 - She's your child by a previous marriage? (I saw that last name on bed was different)
- Mo 5 - Yes (apologetically)
- Ch 6 - I'm sorry . . . that was a nosey question.
- Mo 6 - It's all right.
- Ch 7 - I get used to making these assumptions. (pause) You must be finding this is not an easy experience.
- Mo 7 - No, it isn't. I'm surprised she's lived this long. I didn't know she had so many things wrong with her heart. (blinking back tears) (Again I felt like saying "I sense you're on the verge of tears" but did not)
- Ch 8 - Would you like to have me sit with you for a moment?
- Mo 8 - No, my husband will be back in a moment.

In writing an evaluation of this interview, the writer was aware that he himself was anxious, unable to ask a facilitating question on at least two occasions, and of little help to the mother in this situation. This experience

points out the need of the pastor to be "ready" to help parents. It occurred after the pastor had made several other calls on the pediatric floor and had been "collecting emotional garbage" in other visits. A break of some sort to ventilate and relieve one's own feelings in a long day of hospital visitation seems to be a necessity, lest the pastor unconsciously has his own feelings of crisis and death build up so that he becomes unable to minister adequately to those on whom he calls. Later reference will be made to the article by Vernick and Karon in which the hypothesis about doctors is made that they are not immune to their own feelings about death and therefore do not discuss them with patients. This is probably also true of the pastor's conversations with patients.¹¹ The pastor must then work out his own feelings about crisis and death.

He may find help in Gerard Caplan's Principles of Preventive Psychiatry where crisis is defined.

The essential fact influencing the occurrence of crisis is an imbalance between the difficulty and the importance of the problem and resources immediately available to deal with it. The usual homeostatic, direct, problem-solving mechanisms do not work, and the problem is such that other methods which might be used to side-step it also cannot be used. In other words, the problem is one where the individual is faced by stimuli which signal danger to a fundamental need satisfaction or evoke major need appetite, and the circumstances are such that habitual problem-solving

¹¹Joel Vernick and Myron Karon, "Whose Afraid of Death on a Leukemia Ward?" American Journal of Diseases of Children, CIX:5 (May 1965), 393-397.

methods are unsuccessful within the time span of the past expectations of success.¹²

The more experienced the pastor is in dealing with the death situation, the more likely he is to be aware of the kind of problems he faces in his own feelings. However, the pastor may be tempted to hide his feelings, and to use repression as a way of dealing with his anxiety. Certainly he will not be able to deal honestly and maturely with the anxiety of others if he cannot face his own. Honestly facing one's own crisis feelings, however, often enlarges the quality of empathy and understanding in the pastor. Accepting himself, he will be able to be calm and reassuring in helping others to deal with their crisis feelings.

Dr. Kenneth E. Appel says that a psychiatrist looks for five attributes in a pastor when a patient needs spiritual or religious help: (1) person, or personality, that is a warm, accepting, balanced individual; (2) experience; (3) wisdom (born of experience); (4) knowledge; and (5) skill and courage.¹³ Appel's list is given here because it may be cited as not only what a psychiatrist might expect from the pastor, but also what patients and

¹²Gerard Caplan, Principles of Preventive Psychiatry (New York: Basic Books, 1964), p. 39.

¹³Kenneth E. Appel "The Collaboration of the Pastor and the Psychiatrist," Hans Hoffman, Editor, Making the Ministry Relevant (New York: Charles Scribner's Sons, 1960) p. 84.

families anticipate. The more adequately a pastor has dealt with his own feelings, the more adequately he may make himself available to patients and families to help them ventilate their feelings in times of crisis. His ability to be objective about his own feelings will allow him to reflect more carefully the feelings of those to whom he ministers. Confusion about his own feelings may result in confused reflections. Since his own emotions and responses are the essential equipment the pastor uses in ministry with people, the greater his ability to use these the greater will be his opportunity for pastoral ministry. Becoming aware of these feelings should take place in the pastor's own family and with his own children.

4. His own children. This section of the paper is written on the premise that the pastor is married and has a family. It will not, of course, be applicable to the celibate priest or the single pastor. The experience of this writer and conversations with ministers and with members of the professions indicates that one is least effective in therapeutic help when he deals with his own family. Yet this should be one of the most vital concerns of the pastor. It may well be the greatest opportunity the pastor has to come to understand his own needs in ministering to other children. He should have some method of judging growth in his own children. Jack C. Westman in an article in the Archives of General Psychiatry says that there are

three difficulties in observing nursery school children: (1) the sharply ascending developmental curve may produce gross shifts in personality structure and behavior without implying pathology; (2) existing psychiatric diagnoses cannot be readily transferred to a nursery school; and (3) the wide range of individual differences arising from endowment and cultural background makes the comparison of children hazardous.¹⁴ Despite these difficulties in evaluating children, Westman concludes with five criteria: (1) the quality of object relationships can be assessed by the child's ease in separating from his parents. (2) A child's ability to deal with impulses and fantasies can be assessed through his behavior (3) the capacity to express and control "affects" provides a measure. (4) The adaptability to change reflects the strength of the synthetic function of the ego. (5) The child's self esteem may be judged from his reaction to new activities, attitudes toward his own creations, and interaction with his peers.¹⁵ The purpose of the citing of these criteria is to set forth one example of the ways a pastor may develop his own system of evaluation for his children. As he comes to understand the reactions and behavior of his own children and feels the

¹⁴Jack C. Westman, "Nursery School: Outpost for Preventive Psychiatry," Archives of General Psychiatry (January 1964), 31-35.

¹⁵Ibid., pp. 32-33.

ability to communicate and empathize with his family, he will gain strength for ministering to the hospitalized child. Relating his child's needs to those of the hospitalized child may often be a helpful way of engaging his best parental attitudes toward the child. Parental ability is closely related to pastoral ability with children.

2. PASTORAL ABILITY WITH CHILDREN

There are many conflicting demands on the pastor's time and abilities. The calls of administration, counseling, youth work, preaching, and other values of equal importance are heard by the pastor. Often the call to understand and minister to children is omitted. The pastor's own children may be an instrument to force him to greater understanding of all the children who make up his parish and its associated families. Varied approaches to the nature of pastoral ministry with children have been written. Frank and Mildred Eakin feel that, because the pastor has been relieved of primary educational functions with children, two results have occurred in our churches: (1) the comparatively poor quality of church school education and (2) the comparative detachment of children from the church.¹⁶ This kind of concern lies back of the writings

¹⁶Eakin, op. cit., p. v.

of William E. Hulme,¹⁷ Marion O. Lerrigo,¹⁸ and John Charles Wynn,¹⁹ among others. To illustrate the point of pastoral ability with children the experience of clinical training may be used. The writer spent three months at the Memorial Hospital in Long Beach, working principally on the pediatric floor, become familiar with the children, the nursing staff, the play therapist, and some of the resident and intern physicians. A case study of one particular child reveals some important facts about pastoral ministry with children and relates the sensitivities of the pastor to his own children in sharpening his skills.

The child in the case study is a six year old white male of no professed religious background. He is from a home in which the parents have been divorced, and much of his time has been spent only with his mother. He had been hospitalized because of severe burns in an accident, the details of which were not known. "B" was described by the nurses as "midget seaman," which meant that his language and terminology was more adult than child like. He was known on the floor for his use of profanity. These

¹⁷William E. Hulme, The Pastoral Care of Families (New York: Abingdon Press, 1962), 208 pages.

¹⁸Marion O. Lerrigo, Children Help Themselves (New York: Macmillan, 1946), 219 pages.

¹⁹John Charles Wynn, Pastoral Ministries to Families (Philadelphia: Westminster Press, 1957), 214 pages.

excerpts are from the pastor's first interview with the child:

- Ch 1 - Hello, B. how are you today?
 Pt 1 - Fine. (a bit reticent)
 Ch 2 - You've got quite an outfit here (referring to "cage" which held covers off body)
 Pt 2 - Yea, (smiling back to me). I think I heard "Lucy" on the television.
 Ch 3 - Would you like to watch television?
 Pt 3 - Yes.
 Ch 4 - Is Lucy your favorite program?
 Pt 4 - Yea, one of 'em.
 Ch 5 - Do you have a TV control or would you like me to turn it on from up there?
 Pt 5 - You can turn it on from up there.
 Ch 6 - (turning on set) There. It should warm up in a minute.
 Pt 6 - Hey, you look like her husband!
 Ch 7 - Whose husband? Lucy's? You mean Desi.
 Pt 7 - Yes, you look like Desi.
 Ch 8 - Well, if you think I look like Desi, just call me that. I don't mind. (smiling)
 Pt 8 - (smiling broadly) I like you.
 Ch 9 - I like you too. You know, I have a little boy about your age. He'll be six in July.
 Pt 9 - What date?
 Ch 10 - July 9.
 Pt 10 - That's my birthday! Only I'll be seven.
 Ch 11 - Isn't that something?
 Pt 11 - Yea (smiling)
 Ch 12 - (television now playing and Pt. begins to watch) Well, you want to watch this program I know. I'm going to be around the hospital. I'd like to come back to see you again.
 Pt 12 - Would you?
 Ch 13 - Sure I will. How about this afternoon?
 Pt 13 - O.K.
 Ch 14 - See you then. Bye.
 Pt 14 - Bye (cheerily).

Several points are apparent in evaluating this interview. The pastor accepts the child's "other interest" by calling attention to the television set in his room when the child comments about the program from another patient's room.

This beginning where the child was brought an identification of the pastor with one of the television figures. The pastor's corresponding identification was to his own son which added a second common note when the patient discovered the pastor's son had the same birthday. The rapport was also immediately established by these simple responses and identifications.

The second interview with the patient was brief.

- Ch 1 - Hi, B! (smiling)
 Pt 1 - Hi (smiling in return)
 Ch 2 - How are things going this afternoon?
 Pt 2 - Fine. I spilled some drink on my bed.
 Ch 3 - That's funny. I spilled some coffee on my tray at lunch. I hope we're both entitled to one mistake! (laughing)
 Pt 3 - (laughing) Hope so!
 (Receptionist enters with paint set sent by Mrs. Santa Claus (mother?) and gives it to B.)
 Ch 4 - Well, now you can be an artist!
 Pt 4 - I can't do it too well. It's hard to stay in the lines.
 Ch 5 - Say, I'll bet you I can draw a better picture than you can paint, o.k.?
 Pt 5 - You'll draw me a picture? (quizzically)
 Ch 6 - Sure, will you paint one for me?
 Pt 6 - Yea.

The third interview, the last to be cited, has material of seeming religious significance for "B".

- Ch 1 - Hi, B. How's it going today?
 Pt 1 - Fine (smiling). I saw you in the hall today.
 Ch 2 - Yes, I waved to you on the way back from the physical lab.
 Pt 2 - I didn't get my picture finished.
 Ch 3 - Well, I win--here's mine! (Handing small hand drawn picture to patient)
 Pt 3 - (smiling--which seemed to indicate pleasure that I really had remembered to do the picture from the day before) Is this for me?
 Ch 4 - Sure is.
 Pt 4 - What is it?

- Ch 5 - Can't you guess? An artist wants his work to be appreciated (smiling playfully)
- Pt 5 - It's a house on a hill with a street.
- Ch 6 - Have you ever seen the hospital from outside?
- Pt 6 - Yea, it's the hospital--where's the 4th floor?
- Ch 7 - Ooops! (drawing extra floor) I only made 3.
- Pt 7 - Where's my room?
- Ch 8 - (pointing) about right here--449.
- Pt 8 - Can I keep this?
- Ch 9 - Of course, I did it for you.
- Pt 9 - I didn't finish mine. Will you help me?
- Ch 10 - (picking up follow-the-numbers picture of head of Christ on which B. had been painting)
- (Enter intern)
- In 1 - Hi Chaplain. Hi B! (looking at B)
- Ch 11 - Hello, J.
- In 2 - Drawing a picture, huh? Is that Buffalo Bill?
- Pt 10 - It's Jesus Christ!
- In 3 - I guess that's a long way from Buffalo Bill. (looking at the bandages) You look pretty good today. Keep those legs out straight. (leaving)
- Ch 12 - (handing brush back to patient) Have at it!
- Pt 11 - I can't do this very good--not like on the box. I run over the lines.
- Ch 13 - That's your second mistake, but I guess we'll allow two! (chuckle) (Pt. and Ch. concentrate on painting for a while) Who is Jesus Christ, B?
- Pt 12 - He's the Son of God. He's alive up in heaven.
- Ch 14 - Where did you learn that? In church or Sunday School?
- Pt 13 - Yea, he died but he rose up. (painting) I hope I don't run into that line.
- Ch 15 - It looks as though you'll be busy for a while. I have to go downstairs, but I'll see you tomorrow.
- Pt 14 - Why do you have to go?
- Ch 16 - I'd like to stay, but I have a conference. I've had fun being with you. I'll be back.
- Pt 15 - O.K. I'll finish the picture by tomorrow.
- Ch 17 - It's a deal--see you then.

It seemed significant in writing the evaluation of this case that "B" chose from the pictures available to him one of Sallman's "head of Christ" to paint for the pastor. He responded with a great deal more theological and

doctrinal information than was anticipated from the previous description of his background or that might have been associated with the reputation which he had among the nurses and other patients on the floor. In succeeding sessions the chaplain and the patient were able to continue to discuss the patient's fear of dying and the anxiety which the child experienced over what might be described as an oedipal conflict in his relation to his mother. It was difficult to describe accurately the relationship between mother and son, but the pastor gained the impression from brief contacts with the mother that she was a very depriving person (almost "castrating") which may have caused a great deal of "B's" hostility toward the female personnel on the pediatric floor. In evaluating this case with the chief pediatric nurse, it was felt that the pastor's presence caused "B" to talk about dying, God, and the future which he had not done in the previous weeks of hospitalization. The change in "B's" behavior also was apparent to the nurses, but it was felt by the pastor that this was based more on the relationship to a male figure than any religious significance which the relationship may have had. The role of the pastor may vary from child to child. The pastor's ability to adapt to the needs of the child will increase his effectiveness in the hospital.

It seems to the writer that four questions may be used to guide the pastor in evaluating his own ability with

children and in setting up his perspectives for future growth in this ministry. The first question is, what kind of a person is he? Is he a balanced, accepting, and empathizing individual? Since underlying all pastoral ministry is the ability to communicate understanding, his own personhood should be clearly defined and well developed.

The second question for evaluating pastoral ability is, does he have the basic underlying knowledge of child development and personality? Wisdom is generally defined as the use of knowledge, but the pastor cannot be a wise minister with children unless he has first acquired the knowledge of their physical, emotional, and psychological development. This information can, of course, be gained by reading, by observing children in the church school, in the nursery school, in the hospital, in one's own home or at play. It will undoubtedly require a combination of various methods of study and practical experience before the pastor will become skillful in the ministry with children.

The third concern is whether the pastor has an adequate grasp of his religious resources in the ministry with children, particularly in their crises.²⁰ In addition

²⁰One of the reflections the writer has made on his own clinical experience is that a great deal of information is gained from the fields of psychoanalysis, psychology, medicine, and psychiatry by the trainee, but does this make adequate clinical training? The answer for pastoral ministry, at least for the writer, is that it does not.

to the basic backgrounds in the psychological fields, the pastor must take seriously the resources of scripture, prayer, the sacraments, devotional literature, and other appropriate aids to his ministry. If the pastor does not bring an added dimension of special significance to this ministry, he has no valid claim to being a part of the healing team. The writer feels that the pastor is a part of the healing team and that his use of the resources which we have discussed at length is the key to his significant ministry. The point is that the pastor must be willing and able to use the resources which he has.

A fourth consideration is the way he relates to children. Pastoral ministry with children is not done in isolation. It is not measured only in terms of the facts the pastor has nor in terms of his knowledge of religious resources. It is a relationship. The pastor's ability with children will not be judged by the quantity of his contacts with them, but by the quality of the interaction within the relationship. It is more than being with children that determines the quality of the pastor's relationship; it is becoming child or patient-centered in one's approach that opens the door for more effective ministry. This ability--based on personhood, knowledge, resources, and relationship--is the background for the pastoral care of the child in the hospital. It represents the core of the pastor's needs.

CHAPTER IV

THE NEEDS OF THE HOSPITALIZED CHILD

1. THE EMOTIONAL DEVELOPMENT OF CHILDREN

In order to discuss intelligently the needs of the hospitalized child, it is first essential that one understand the development of children. As a basic source for this discussion the writer relies upon the insights of professor Erik H. Erikson in his volume entitled Childhood and Society. He discusses the "eight stages of man:" (1) infancy, (2) early childhood, (3) play age, (4) school age, (5) adolescence, (6) young adult, (7) adulthood, and (8) mature age. The first five stages become the frame work from which the material in this paper will be discussed. While Freud based his system of human development on the psycho-sexual phases, Erikson developed the stages around the critical experiences in the totality of the child's life.

1. Trust versus mistrust. The first stage which Erikson calls infancy is the period in which the child develops a sense of trust in contrast to basic mistrust. The word trust means confidence, but is chosen by Erikson because, as he puts it, it contains "more naivete and mutuality" than the word confidence. Erikson believes that the absence of basic trust in the child is the cause for

infantile schizophrenia. "The re-establishment of trust has been found to be the basic requirement for therapy"1

Trust is established in the home as the infant finds the maternal figure and gradually the paternal figure to be reliable and, in some senses, predictable in patterns of behavior. The child learns that the parents, particularly the mother, will provide the security from which he can develop a relationship at later stages. Adjustment and growth for the infant comes as he is able to find meaning and relationship in these experiences. Erikson says, "ultimately, children become neurotic not from frustrations, but from lack or loss of societal meaning in these frustrations."² When the infant is hospitalized, his life pattern is disrupted; and he must now make new adjustments that are affected by his sense of trust and mistrust. The infant may, therefore, experience anxiety, insecurity, and fear when he is hospitalized.

Bowlby pointed out five mechanisms of survival for the infant, or what one might call forms of attachment behavior. They are sucking, smiling, crying, clinging,

¹Erik H. Erikson, Childhood and Society (New York: Norton, 1950), p. 219ff. It should be noted at this point that all further discussion of Erikson's stages will be based on this chapter in his book.

²Ibid., p. 222.

and following.³ When the child uses these five mechanisms of survival, or attachment behavior, and persons around him respond with attitudes and feelings that allow him to sense security and structure, he is developing the basic trust of life. Walking through a pediatric ward in a hospital one may observe that the infant's pattern of life has apparently been disrupted, though his sense of trust may not necessarily be permanently impaired. The infant demonstrates his basic fears and anxieties by sucking, smiling, and crying. These symptoms particularly relate to Freud's oral stage of life when the mouth is the central instrument of communication, intake and output. The child will cling to a nurse, a pastor, a doctor, or a play therapist until restricted to a bed. If allowed he will follow any person who has become a significant individual through the corridors, play rooms, or any other unrestricted areas of the hospital.

The effects on the child of separation from parents, emotionally as well as physically, have been recognized by many hospitals. The Long Beach Memorial Hospital, for instance, is one among many which now has no restricted visiting hours on the pediatric ward. This allows the mother to spend as much time as possible with the hospitalized infant and to continue the sources of care which

³J. Bowlby, Maternal Care and Mental Health (Geneva: World Health Organization, 1952).

produce the basic trust in this early stage of the child's development.

Basic trust and mistrust are not just the concerns of parents, however; they are also the concerns of the pastor. This, as in the other stages suggested by Erikson, demands of the pastor a sensitivity to the developmental needs of the child and his role in creating and promoting an atmosphere which will encourage trust by the infant. For Erikson therapy has as its goal the re-creation of basic trust. The church also has this same aim as one of its basic goals, if not its most important. While the pastor's primary role in dealing with the infant will undoubtedly be far more concerned with the support, encouragement, and instruction which he may give to the family--which we shall discuss in the next chapter--he may be a significant person in the life of the infant during hospitalization. Thus, his awareness of the developmental process and his ministry to the infant may contribute to the basic foundation of trusting human beings. This is a prelude, if not the actual experience, of trusting God.

Verbal skills are of little help in ministering to the needs of the infant. Communicating assurance, strength, and security to the infant is basically done by the use of affective and non-verbal communicative skills. The warmth of touch, the relaxed and soothing quality of the voice, and a poised and gentle manner should be used in

communicating security to the child. The pastor's belief in the efficacy of non-verbal communication is essential in his ministry to the infant.

While a great deal of research needs to be done about infants, there is evidence against any assumption that relationship to significant persons is unimportant. The infant may experience grief in the breaking of such a relationship. Although some disagree, Bowlby claims that this takes place as early as six months.⁴ That the child is able to experience and associate objects and persons at an early stage is one of the assumptions of the work of Arnold Gesell.⁵ It is sufficient for this dissertation to say that the pastor must take seriously his relationship, however limited, to the infant as well as to his family. He participates in the child's development of trust.

2. Autonomy versus shame and doubt. Erikson's second stage of man is the one in which anal-muscular maturation brings experiments in holding on and letting go. The child learns in this period, which Freud called the anal stage of psycho-sexual development, that he can please his parent by giving or displease the parent by withholding.

⁴Cited in Robert A. Furman, "Death and the Young Child" in The Psychoanalytic Study of the Child (New York: International Universities Press, 1964), 323.

⁵Arnold Gesell, et. al., The First Five Years of Life (New York: Harper and Bros., 1940), p. 36.

The child also begins to experience that he may use bodily functions as aggressive tools in relationships to others. Erikson believes that autonomy is developed in the assured, trusting relationship carried on from infancy in which the child is able to work through the frustrations connected with anal-muscular maturation without incurring shame and doubt. The child incurs shame when he is self-conscious, "exposed but not prepared," and doubt is associated with "the behind" in the child.⁶

That the pastor's understanding of the struggle in the child (now in the period between eighteen months and three years of age) is significant to his hospital ministry may be readily seen. The child is placed in an environment which is strange. In the hospital someone other than his significant parent now begins to examine his body and may react so as to "shame" him for his lack of control in the anal functions. The fact that he is separated from his parents will only compound the reactions that he has during this period.

In his book An Approach to Community Mental Health, Gerald Caplan has high praise for a film made by Dr. James Robertson entitled "A Two Year Old Goes to the Hospital." The film exhibits the three stages through which a twenty-nine month old girl goes during seven days in the hospital.

⁶Erikson, op. cit., p. 222.

Dr. Caplan and Dr. Robertson note that the operation for which she was hospitalized was unnecessary and that the seven day period of hospitalization was too long. The film is, however, a significant study in the child's reactions. The three stages demonstrated are (A) protest, (B) despair and (C) adaptation. Several conclusions are drawn from the material observed. First, a stronger protest is lodged the closer the bond to the mother and the less the child has been separated from his mother. Second, the signs of despair are depression, resignation, hostility towards the mother, the mother substitute, or the self. The hostility is a result of the child's feeling that the mother has rejected her because of her "badness." The child in return shows some aggression, by saying "I want mummy," but turning away from the mother when she arrives. Third, the period of adaptation (after a week) sees the child denying the need for mother, denying affection for mother, and "playing" a game "I will not recognize you, mother." This denial may continue after the child has gone home until she finally reverts to an overdependent stage.⁷

The significance of this study for this paper is that it essentially agrees with the conflict spelled out by Erikson in the autonomy versus shame and doubt period for

⁷Gerald Caplan, An Approach to Community Mental Health (New York: Grune and Stratton, 1961), p. 124ff.

two year olds. The child protests the loss of autonomy in being confined to the hospital where she is given orders, required to eat what is served her, and made to take medicines and receive shots which she does not choose. Both shame and doubt may be seen in the period of her despair as she exhibits the symptoms of depression, resignation and hostility. In the experience of separation from her parents the child doubts their love and trust because she fears that the hospitalization and the sense of rejection which she has are a result of some misdeed on her part.

William S. Langford suggests that hospitalization is always "a stress situation of anxiety and uncertainty for most children." He goes on to note that the symptoms of withdrawal and depression are simply statements of fear and denial that grow out of the complicated emotional responses to being separated from the parents, the feeling of being punished for misdeeds, the loss of independence, and dietary restrictions. All of these may mean to the child that he is unloved, mistreated or neglected.⁸

Lawrence B. Slobody also suggests that "behavior difficulties may arise when the basic security of the child is threatened." Three basic threats--parental rejection,

⁸William S. Langford "The Child in the Pediatric Hospital: Adaptation to Illness and Hospitalization," American Journal of Ortho-Psychiatry, XXXI (October 1961), 667-684.

sibling jealousy, and overprotection--create behavior difficulties in the child. Hospitalization falls in the category of parental rejection.⁹ Richard K. Young also suggests that separation is often interpreted by a child as rejection.¹⁰ Since the child is working out his basic sense of autonomy in relationship to parents, the process must be begun again or modified in relationship to those whom he meets in the hospital. Those who work with him become significant persons to the child during his period of hospitalization. Their failure to treat him as a person, not an object, may be very important in his continuing sense of autonomy. While communication with a child of this age may be very difficult, the pastor, like the hospital personnel, will be called upon to minister to the child as an individual. His failure to do so will make him simply a part of the world of shame and doubt rather than a part of the experience (which the child needs) of assurance and understanding.

3. Initiative versus guilt. In the period of approximately three through five years of age which Freud called the oedipal stage, Erikson describes the development

⁹Lawrence B. Slobody et. al., Survey of Clinical Pediatrics (New York: McGraw-Hill, 1963), p. 54.

¹⁰Richard K. Young, The Pastor's Hospital Ministry (Nashville: Broadman Press, 1954), p. 122.

of the child as working through the conflict of initiative versus guilt. During this period the child learns that there is pleasure in attack and conquest. He plays games in which his "overcoming" ability is stressed. He takes the initiative in action and finds the reward for having accomplished something by himself. Yet over against this there is the guilt of initiative expressed in what he considers to be "wrong directions." Erikson says this conflict is "expressed in hysterical denial or abrogation of its executive organ by paralysis or impotence."¹¹ He seems to describe at this point what is called in Freudian terminology the "castration anxiety." This refers to the fear of the boy in the play age, as Erikson calls it, who is afraid that his father will castrate him if he knows of the pleasurable or erotic feelings that the boy has toward his mother.

It is important during this period for the pastor to be aware of the role of play and toys for the child. There is also a certain attachment to special equipment, like a telephone, which children exhibit during this stage of development. As a clinical trainee the writer experienced the following kind of reaction in a four and a half year old girl, whom he had seen on several occasions with her parents present. She had always previously acted as

¹¹Erikson, op. cit., p. 224.

though she would cry and had never spoken to me. On this occasion she was alone in her room.

- Ch 1 - Hello, Julie. How are you today?
Pt 1 - Fine (smiling broadly)
Ch 2 - It's nice to see that you're so happy today.
Pt 2 - (smiling) yes.
Ch 3 - (glancing at TV) Are you watching your favorite program?
Pt 3 - No, just listening. (pointing to other bed). She went away with her doctor, but she's coming back.
Ch 4 - She must have gone for a treatment. (noticing toys on bed) You've got a lot of nice toys here at the hospital, Julie.
Pt 4 - I have a baby at home.
Ch 5 - A doll baby or a real baby.
Pt 5 - A real baby . . . he's one.
Ch 6 - Do you take care of the baby?
Pt 6 - Yes. So does my brother . . . he's five, but he doesn't share with me.
Ch 7 - Do you share with him?
Pt 7 - Yes. (fingering the rail and the telephone)
Ch 8 - Have you talked to your brother on the telephone?
Pt 8 - Yes, and to my mommy and daddy too. And my friends.
Ch 9 - Well, you have something special here in the hospital that you don't have to share with your brother, don't you?
Pt 9 - Yes.
Ch 10 - It's not always easy to be in a hospital. The first few days it didn't feel very good, did it?
Pt 10 - No, my leg hurt, but it's better now.
Ch 11 - You're a pretty big girl and you've gotten better while you've been here.
Pt 11 - (smiling) I'm fine now.
Ch 12 - Pretty soon, you'll have that leg out. It looks like it's sunburned (chuckling).
Pt 12 - Yea (snickering)
Ch 13 - I'm glad I got to see you today, Julie. I'll come back on Monday to see you again.
Pt 13 - O.K. (smiling) Bye. Bye.

Several things may be noted from this clinical report. First, the child seemed to be aware that she had the liberty to speak when her parents were not present. It was later discovered by the writer that the little girl

had run into the street while playing with some other children and had her leg broken by an automobile which ran over her. The parents apparently had made her feel very guilty for going out to play with her other friends without permission and implied that this was the kind of "punishment" that she would receive every time this sort of thing occurred. The mention of nice toys by the chaplain gave Julie an opportunity to discuss the close relationship between toys and people. Being aware of her movements toward the telephone also allowed her to share something of her sense of satisfaction about being able to talk to friends on the phone. The interview is not significant in that it demonstrates prime examples of the play age, but it does point out several of the kinds of responses which are appropriate to the Erikson formula.

4. Industry versus inferiority. The fourth stage of child development which Erikson lists is called the school age. The basic conflict involved is that of industry versus inferiority. The child seeks to win recognition by producing things. At this developmental stage he gains pleasure in the completion of the task. This period in the psycho-sexual developmental schedule is called latency. The child is far more concerned about groups of the same sex and is "at rest" in his sexual development before he enters the adolescent period in which the infantile sexual

urges of the oedipal stage revive. It is a "gang" period in the development of the child; here the question of industry versus inferiority may be seen quite clearly. If the child is able to produce among his peers so that he may hold his head high and be proud of his activities he will not experience as much conflict or difficulty in the adjustments of this period. If, however, he finds that he cannot compare well with his fellows, the question of inferiority becomes an urgent one. He may in fact revert to patterns of behavior which are more infantile and selfishly demanding. While his behavior is infantile, the fantasies with which he lives may be quite adult. In the following interview with a seven year old white male, who was hospitalized forty-five days and with whom the chaplain had had little relationship, the adult fantasies of living alone, drinking, smoking and so-forth, were quite evident in the child's attempts to impress the chaplain.

Ch 1 - Hi, B. How are things today?

Pt 1 - I got the stitches out of my leg. (smiling) I may get to go home Saturday.

Ch 2 - That's great news, isn't it?

Pt 2 - Yea, I guess it is. That's my T.V. I have my own at home too, only it's color and has remote control. I'm going to break my leg when I get home.

Ch 4 - Why are you going to do that?

Pt 3 - Because my mother has been giving me a dollar a day while I've been sick. I have \$45.00 now, and I want to keep going.

Ch 4 - It sounds like money is pretty important to you.

Pt 4 - Yea, when I get out I'm going to San Francisco for a month.

Ch 5 - You have relatives there?

- Pt 5 - No, I'm going to leave my brother and sister and mother and father here and go alone.
 Ch 6 - That will be very unusual for a seven year old to go to San Francisco all alone.
 Pt 6 - I can do it. I was there before by myself.
 Ch 7 - I think you're putting me on! I'll bet your grandmother lives in San Francisco.
 Pt 7 - Yea, she does. When I was three years old, I drank five glasses of----brandy. I fell off the chair.
 Ch 8 - I think I'd fall off the chair too!
 Pt 8 - My dad let me smoke one of his cigars too.
 Ch 9 - That's unusual, a seven year old smoking cigars.
 Pt 9 - And I've smoked cigarettes too.

Here the child continues to seek relationship by the use of "adult" expressions of independence, as he apparently sees them. Feeling insecure, he imagines a world of behavior which is actually beyond his experience.

One contribution to a child's insecurity may be that the parents are still struggling with keeping the child from expressing the new found industry and autonomy that comes during this period of development. An interview with a six and a half year old white female where the mother was present exhibits some of the ways in which a mother will attempt to answer for her child, even if the pastor is endeavoring to relate to the child.

- Mo 1 - I'm Mrs. W. This is D, my little girl.
 Ch 2 - It's nice to meet you, Mrs. W. How are things going, D?
 Pt 1 - Fine. I.....
 Mo 2 - She's fine now. Just tests this time, but we'll need everyone's help we can get in a couple of weeks.
 Ch 3 - You expect some surgery?
 Mo 3 - Open heart. She's a bit apprehensive about it.
 Ch 4 - I'm sure I would feel apprehensive too. (to Pt)
 Is that a real live kitty?

- Pt 2 - (Laughing) No, It's not real. It's just make believe.
Ch 5 - It looks real. It's very pretty.
Pt 3 - I have a real kitten at home. My sister has a horse and I like to ride it.
Mo 4 - There won't be much of that soon.
Ch 5 - I'll bet that's fun. (pause) You must be about 6-1/2 years old.
Mo 5 - Yes
Pt 4 - How did you know?
Ch 7 - I just guessed--You look like a 6-1/2 year old who is in school.
Pt 5 - I'm going to be in the second grade.
Ch 8 - Good for you!

The chaplain in this case was a stranger to both the patient and the mother. The child responded when given the opportunity, but the mother attempted to answer on behalf of the child. Pastoral visitation without the parents is probably the best plan for the pastor who is familiar to the child. It is possible, however, that when the pastor is unfamiliar to the child, he should make his first visit with the parents present. The child, then, has a good frame of reference for relating to him. The pastor may often be mistaken for the doctor in the hospital setting. The child who is unfamiliar with the minister may mistake him for some other person in the hospital or be confused about the minister's role and purpose. The following interview shows a nine year old white male's lack of understanding about what a chaplain is and points out that one must define his role clearly for the child.

- Pt 6 - Are you a doctor?
Ch 7 - No, I'm a chaplain, a minister.
Pt 7 - What's a minister?

- Ch 8 - Do you have a minister where you go to church or Sunday School?
- Pt 8 - I don't go to church. I went to Bible School last summer in San Diego with friends, but Mom says it's too much trouble to get all of us dressed. I have three sisters.
- Ch 9 - That is quite a family. Do you have a chaplain on your Dad's ship or the base?
- Pt 9 - What's a chaplain?
- Ch 10 - Well, a chaplain is a name for a military minister or men like I am here in the hospital.
- Pt 10 - What do you do?
- Ch 11 - The minister teaches people about God. Here in the hospital I visit patients and talk to them; sometimes I say a prayer for a patient. On your radio we have a chapel service.
- Pt 11 - I saw a story on television once about a man who was a minister, but he was a German and not a real minister. They found him out when he stabbed a man.
- Ch 12 - (opening coat) Well, I don't have any hidden knives to stab you with (chuckling).
- Pt 12 - You're a good guy, though; you're not one of the bad guys like he was.
- Ch 13 - T. has to stay here 14 days! (referring to Pt 2; a brief chit-chat between Pts and Ch).
- Ch 14 - It has been nice to visit with you boys. I'll see you tomorrow T. Good luck, B. Goodbye.

5. Identity versus role diffusion. The fifth stage of Erikson's eight stages of man and the final one for our purposes in describing children is called adolescence. The basic problem of adolescence is the conflict between identity and role diffusion. Erikson points out that this identity is more than the sum of childhood identifications. The danger of role diffusion is the ultimate uncertainty of identity.¹²

¹²Ibid., p. 226.

The teenage child is in the psycho-sexual developmental stage called puberty. He is now capable of carrying on adult sexual relationships, reaching orgasm, and bearing children. The conflict in the adolescent results from failure in earlier stages of development which causes him to be uncertain of his own identity. The lack of adequate male or female figures to whom he can relate may indeed produce inadequate patterns of relating throughout the rest of his life. He becomes uncertain about his role in life and therefore questions his significance. The choice of an occupation becomes a primary concern, and the failure to meet that choice often is interpreted in unusual ways. The following interview demonstrates one girl's experience of hospitalization and how she interpreted it in the light of her experiences and her career expectations.

- Pt 5 - I can't seem to sleep well either. I stayed up til 1:30 or 1:45 this morning, before I turned my light off.
- Ch 6 - You feel better with the light on.
- Pt 6 - It's easier to lie awake and think that way.
- Ch 7 - You've had a lot to think about?
- Pt 7 - Yea (squeamishly)
- Ch 8 - Would you like to talk about it?
- Pt 8 - Yes, I would . . . I was thinking first about how God might be punishing me to show me that I shouldn't have a career. I want to be a nurse, and you can't be a nurse with a bad back.
- Ch 9 - You think God might be the cause of your being hospitalized?
- Pt 9 - Well, yes, God makes things happen to us, or lets them happen so he can teach us.
- Ch 10 - Someone has told you that God causes all things to happen to us?
- Pt 10 - No, I just believe that. I guess I have faith that God will take care of me.

- Ch 11 - Faith can be a very important thing in our lives.
- Pt 11 - When something has happened to you, you can help others. Like this man in our church, Bill Fry, who just got out of the hospital with a bad back. He came by to visit me yesterday when he knew I had a bad back.
- Ch 12 - You found his visit helpful?
- Pt 12 - Oh yes.
- Ch 13 - I'm glad you're so courageous about your hospitalization, B. I'll be interested in how things go for you. I'll come again tomorrow to see you.
- Pt 13 - Please do. I'm glad you came.
- Ch 14 - I'll be remembering you in my prayers.

One can see the need for a close association between the actual events of this child's life and her belief in God's ability to "make things happen to us." Her responses indicate that she has some conflicting ideas about God, about being a nurse, and perhaps about her identity. Her sense of meaning is tied to her idea of God.

The stages of emotional development in a child are of such significance that the pastor's understanding of these needs of the child will cause him to vary approaches and kinds of ministry, depending on the child's age and background. What the child needs will determine the ministry the pastor provides. The needs of the child limit the ministry he can receive from the pastor. As Francis McOlash, Chaplain of the Fairview State Hospital at Costa Mesa, California, has pointed out:

it is one of the fundamental assumptions . . . that emotional-spiritual growth comes about through relationships. An essential element of this concept is the capacity of the religious worker to make

himself available to the child and to communicate to him a sense of being understood.¹³

Russell Dicks in Pastoral Work and Personal Counseling has also pointed out that in the hospital ministry we must follow the patient because we are the "medicine" and the patient is the "physician."¹⁴ Dicks and McOlash are thus pointing to the central point the writer wishes to make. Pastoral ministry with hospitalized children, to be effective, must be child-centered. Further, the pastor's ministry will be more effective if he knows the basic types represented in Erikson's five stages of childhood. He will then be able to make himself available in a way which children may receive. The child responds to him as a helping human person. This response to a helping human person is seen by Bowers,¹⁵ McOlash,¹⁶ Dicks,¹⁷ and Westburg,¹⁸ among others as the essential ingredient

¹³Francis McOlash, "A Relational Concept of Religious Nurture Applicable to a Residential Treatment Program," Journal of Pastoral Care, XVII:4 (Winter 1962), 206.

¹⁴Russell L. Dicks, Pastoral Work and Personal Counseling (New York: Macmillan, 1964), p. 101.

¹⁵Margarita K. Bowers, Conflicts of the Clergy (New York: Thomas Nelson and Sons, 1963), p. 232.

¹⁶McOlash, op. cit.

¹⁷Dicks, op. cit.

¹⁸Granger Westburg, Nurse, Pastor, and Patient (Rock Island, Ill.: Augustana Press, 1965), p. 21.

in pastoral ministry. It underlies the ability of the child to respond to God. As the child's needs are understood by the pastor, he can move on to a deeper understanding of divine response to his needs.

2. SPECIFIC PROBLEMS

Some exceptions to the general principles stated in the earlier paragraphs will need to be noted. The following problems related to the retarded, the physically handicapped child, the critically ill or dying child, the anxious child, the emotionally disturbed child and the child facing surgery are set forth as further aspects of the needs of the hospitalized child.

1. The retarded child. The retarded child is an exception to the general emotional development of children as outlined in Erikson's stages earlier in the chapter. "Retarded" indicates that he has arrived at some stage of development later than most children do. Two books that treat the problem in relation to pastoral ministry are Charles F. Kemp's The Church: The Gifted and Retarded Child¹⁹ and Sigurd D. Petersen's Retarded Children: God's Children.²⁰ They deal extensively with the problem of the retarded child from the standpoint of the church's

¹⁹Charles F. Kemp, The Church: The Gifted and Retarded Child (St. Louis, Mo.: Bethany Press, 1957), 189 pp.

²⁰Sigurd D. Petersen, Retarded Children: God's Children (Philadelphia: Westminster Press, 1960), 152 pp.

responsibility. Petersen's basic point is that the retarded child is made of the same "stuff" of which all persons are constructed.²¹ The problems of the mentally retarded child are to be distinguished from the physically handicapped. The mentally retarded may be a form of regressed development. The pastor's ministry is to a child that is chronologically of one age but maturationally of another age. This writer's experience in dealing with a sixteen year old girl is reported in the following interview.

Ch 5 - You seem to feel very keenly about your sister.

Pt 6 - Me and Pam have always been close, since we're sisters. They just found out about a year ago April she had this disease. We just bought a new house and it's taken all the fun out of it on account of Polly not being with us. We thought she was gonna die. We made all the arrangements to fly her home, but then she got better.

Ch 6 - Where is home, P?

Pt 7 - Buena Park . . . Oh you mean where we would take P . . . That's Arkansas. We have our family lots there. My father was buried there. I was the only one that stayed until he was buried . . . everybody else went home early. Pam's funeral will be harder than my father's.
(pause)

Ch 7 - Because you're closer to your sister?

Pt 8 - Yes . . . We've been awfully close. Even if she comes home, she'll have a special room. We've always had the same room. I hoped they would bring Pam back here to my room so I could be with her. (a slight tremble)

Ch 8 - Are you chilly? (Offering robe on back of chair)

Pt 9 - No, I'm not cold.

²¹Ibid., p. 26.

- Ch 9 - It's very difficult to talk about this, isn't it?
- Pt 10 - What?
- Ch 10 - Funerals, death, etc.
- Pt 11 - Yes (long pause)
(Feeling the patient tiring, I moved to close)
- Ch 11 - I'll be glad to talk about this again with you if you like.
- Pt 12 - All right.
- Ch 12 - Would you find it helpful to have a prayer for Pam?
- Pt 13 - Yes sir.
- Ch 13 - Dear God. We thank thee for this visit with Polly. Give her strength. Bless Pam we pray and be with her in her suffering. May Thy will be done in her life. Make this a good day for Polly and Pam. In Jesus name. Amen.

The chaplain in this interview had been informed that the sixteen year old patient has the mental maturation age of twelve. When this information is given to the pastor, he may find that his knowledge of human development allows him to help the child who, though physically older is mentally a younger child.

This information however is not always available. The pastor may be called upon to deal with a child without specific information about retardation or without knowing the maturational age of the child. The pastor relates to the child as Sigurd Petersen has suggested in the world of "persons" rather than of classifications.²² The need of this child as with others is acceptance as a person.

Petersen also suggests, "There is an uncanny sense of personal and collective guilt, though not easy

²²Ibid., p. 25.

definable, nevertheless real because of our unconscious identification with people."²³ Thus his ministry with the retarded child will be effective only as the pastor is first able to deal with his own feelings toward retarded children. He then can be open to the needs of the child as a person. The retarded child is already keenly aware of many experiences of rejection at the hands of other people. The pastor's greatest ministry to this child may be the fact that he does not reject the child, but accepts him. The retarded child whose activities are limited may be forced to use imagination and fantasy as a substitute for sharing in things that he sees other children doing, either in the real world or through films and television. The pastor will help this child to ventilate his feelings. Otherwise the pattern of avoiding reality may be reinforced in the child.

2. The physically handicapped child. Dr. William Cooper has suggested that the goal of the medical practice with the physically handicapped is employment. "If the patient finally is employed, we have succeeded. If he is not employed, we have failed."²⁴ This general assumption

²³Ibid., p. 27.

²⁴William Cooper, M. D., "The Emotional Problems of the Physically Handicapped Child" in Samuel Liebmann, ed., Emotional Problems of Childhood (Philadelphia: Lippincott, 1958), p. 163.

is based on five generalizations for the physician: (1) that social and emotional problems exist in the child, which are not focused on physical factors alone, (2) that these factors influence social and physical progress, (3) that physicians must attend to the parents early in dealing with the physically handicapped child, (4) that the doctor must work to bridge the gap between hospital, office, and home for uniformity of understanding and consistent handling of the child, and (5) the doctor must lend his authority to the creation of social institutions which are essential to the medical treatment.²⁵ Several questions arise. What assurance is there that employment will aid uniformity of understanding and consistent handling? Does not satisfactory employment involve not only the "handling" of the person but also his "relating" on a mutual basis? Examining these premises points to the kinds of needs that the pastor faces in his ministry to the handicapped child. The child's problem may be more than his physical handicap alone. The pastor should be aware that emotional and spiritual factors will effect the social and physical progress of the handicapped child. The pastor, the physician, and the parents must work toward uniformity of understanding and consistent relationship by cooperation. He

²⁵Ibid., p. 163.

too will lend his authority to the creation of social institutions and groups which will help the child to accept himself, even with his handicap, and be at home in the universe. The pastor's goal, however, is not just employment but also adjustment to as much of life's totality as possible. In helping the patient to become adjusted and relate to those around him, the pastor contributes to new wholeness. Wholeness in relationship with others may well bring the patient to a new sense of relationship to God.

That the physically handicapped child is concerned about relationship to God and to others is apparent from a study by Douglas G. Cater, the Protestant Chaplain at the Illinois Children's Hospital. Chaplain Cater points out that the personality and religious outlook of the physically handicapped child are affected by four factors: (1) the nature of his disability, (2) the stage in his development when the disability was acquired, (3) the attitude which his parents took toward his disability, and (4) whether or not it forced him to be separated from his parents during the critical years.²⁶

The seven conclusions which Chaplain Cater makes in

²⁶Douglas G. Cater, "Some Observations Concerning Religious Ministry to Institutionalized Physically Handicapped Children," Journal of Pastoral Care, XVII (1963), 85-92.

his article are significant for pastoral ministry. He says that (1) "these children, probably more than most children, seem to feel a need to have a theory of 'God's purpose'."

(2) The child's needs vary based on past religious training in the home and church, the nature of his problem and the suffering involved, and most important, the quality of interpersonal experiences the child has had. (3) Most physically handicapped children become interested in faith healing. (4) Many children seem to feel that physical handicaps are the result of punishment for someone's misdeeds. (5) Distorted ideas of dependence often cause feelings of a sense of lack of worth or lack of responsibility in the physically handicapped child. (6) These patients find it difficult to "love their neighbors" in terms of spontaneous concern for them. (7) There is a great deal of feeling about guilt in the physically handicapped child.²⁷

These observations should be helpful to the pastor's ministry. The child's hostility cannot be accepted and dealt with if the pastor feels it necessary to "protect God" or to justify the divine purpose in the child's handicap. The past religious training of the child, may produce varying degrees of problems in the child's suffering and result in different qualities of interpersonal experiences.

²⁷Ibid., pp. 90-92.

The temptation in this encounter will be to debate with the child about God's purpose and the meaning of his illness, but this kind of dialogue may miss entirely the child's feelings. As in the case of the two year old who was filmed by Dr. Robertson, lying back of the child's protest over his illness, or even seeming acceptance of it, may be the mood of despair. To sense with the child that despair, helping him to know that he is understood, is the first step in ministry with the handicapped child. The pastor assures the child of God's love and shows that his handicap is not a punishment as he himself shows his love to the child and remains non-judgmental in his attitudes. The basic relationship to this child, although his problem may be different, will be an accepting, supportive, and listening role in which the child feels that he is understood and allowed freedom to be himself. If this freedom is not granted, the distorted ideas about dependence as cited by Cater will grow in the child. The need of the child will demand from the pastor that he gives the child a sense of worth and responsible sharing in relationship to him and others. The physically handicapped child's experience of love from the pastor helps him to develop love for his fellow patients, his family, and his acquaintances. The most obvious point Cater makes for pastoral ministry is about guilt. In dealing with guilt the pastor's part on

the healing team is clearly seen. He becomes a representative agent of God's forgiveness.

The sense of forgiveness may be the greatest need that the physically handicapped child feels. As Nietzsche has said, "He who has a why to live for can bear almost any how."²⁸ Nietzsche's comment is particularly pertinent in the ministry with the handicapped child because it focuses on the direction of that ministry. The need of the child demands of the pastor an empathy with the feeling of despair. He helps him adapt to the circumstances by sharing a relationship that offers him the hope that he can relate to others. This is at the heart of the healing ministry of the pastor.

3. The critically ill or dying child. The critically ill or dying child presents special problems in pastoral ministry in relation to the family which we shall discuss in our next chapter. The concern of this section, however, is how the pastor relates to the patient. Three particular sources have been helpful to the writer in thinking through the questions of the dying or critically ill child: Edgar Jackson's latest book Telling a Child

²⁸As cited in W. A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, N.J.: Prentice-Hall, 1964), p. 6.

About Death;²⁹ an article in the International Journal of Religious Education by Helen H. and Louis J. Sherrill entitled "Interpreting Death to Children;"³⁰ and an article in The American Journal of Diseases of Children by Joel Vernick and Myron Karon entitled "Whose Afraid of Death on a Leukemia Ward?"³¹ These represent a new realism in the approach to the question of death. What the authors see as non-realistic is the more general approach in which the child is "protected" by being separated from the facts. Protection is seen in this context to be keeping the child away from the body of a person who has died, not allowing him to attend a funeral service, and answering his questions by presenting far-fetched tales or avoiding the real facts. This more realistic approach is in harmony with the kind of child-centered approach the writer of this paper has taken. Its results speak for themselves. In the article by Vernick and Karon, the conclusion notes "only thirty per cent of such children exhibited anxiety about death."³² These children were faced with the realistic approach to

²⁹Edgar N. Jackson, Telling a Child About Death (New York: Channel Press, 1965).

³⁰Helen H. and Louis J. Sherrill, "Interpreting Death to Children," International Journal of Religious Education.

³¹Joel Vernick and Myron Karon, "Who is Afraid of Death on a Leukemia Ward?" American Journal of Diseases of Children, CIX:5 (May 1965); 393-397.

³²Ibid., p. 397.

their death. The conclusion is based on a study at the medical branch of the National Cancer Institute for one and a half years in 1963 and 1964. Children's workers were assigned, allowing each child to talk about anything he wished and the worker was instructed to "exploit an appropriate experience of the day to help the child work on the specific problems of adjustment."³³ The authors cite the need for calling in special workers to deal with the questions of the child because doctors avoid discussing death. Two reasons are cited: (1) because doctors are oriented toward curing and (2) they are not immune to their own feelings about death, even though they, too, would justify the lack of conversation about death as "protection" for the child. But the conclusion of the study is "in order to help a child cope with the problems of serious illness, it is necessary to develop an environment in which he feels perfectly safe to ask any questions and completely confident of receiving an honest answer."³⁴ At the center of this medical community's approach to the critically ill or dying child is a basic honesty. This insight is also applicable to the pastoral ministry with these children. If the child senses the pastor cannot deal with the subject with some degree of strength, he may outwardly accept the answers a pastor gives; but inwardly he will feel

³³Ibid., p. 393.

³⁴Ibid.

abandoned--alone when he needs help most. The article just cited also contends that "every child who is lying in bed gravely ill is worrying about dying and is eager to have someone help him talk about it."³⁵

The way in which one deals with death will differ depending on the age of the child and the stage of his emotional development. The pre-school child can only accept a limited explanation of death. Frances Ilg and Louise Ames in their volume entitled Child Behaviour contend that "truth is the fundamental asset in dealing with death."³⁶ The ability of the child to receive information about death should not be overlooked by the pastor. The five year old is typically calm and "matter of fact" about death while the six year old is more violent and emotional, connecting death vaguely to old age. The six year old carries the notion that death is somehow reversible and those who die will come back. Ilg and Ames advise that the six year old is "so emotional that he should be spared contact as much as possible."³⁷ The seven to nine year old child is more interested in the details and is often reasonably clear about death. At seven he has begun to

³⁵Ibid.

³⁶Frances Ilg and Louise B. Ames, Child Behaviour (New York: Harper and Bros., 1955), p. 309.

³⁷Ibid.

suspect that he also may die, while at eight his interest is more expansive and less morbid than at age seven. By eight many can accept the fact that everyone eventually dies. From nine to ten and older the child can receive as full an explanation as one can give.³⁸

These observations of Ilg and Ames essentially agree with those in the article by the Sherrills who base their information on the studies of Maria Nagey at Budapest, Hungary. There are three essential phases supported by these studies. The first is from age three to five in which the child denies death as a regular and final process and sees it more as sleep or as taking a journey and returning. From five to nine the child tends to "personify death," not yet accepting it as a final process. The third stage begins at age nine when the child begins to accept death as inevitable for all persons and something that can come to him.³⁹ This factual approach to death and sharing honestly with the child also is supported by J. R. Morrissey whose studies show that all fifty-one patients observed functioned normally, and withdrawal and depression occurred infrequently.⁴⁰ Beyond this factual, informational level of approach to the dying child, pastoral ministry also brings

³⁸Ibid., p. 311. ³⁹Sherrill, op. cit., p. 3.

⁴⁰J. R. Morrissey, "Children's Adaptation to Fatal Illness," Social Work, VIII (1963), 81.

the interpretative level. This interpretation of death has its earliest preparation with the first religious concepts a child gains from his parents, teachers, and pastor. Essentially the New Testament under the heading "eternal life" teaches that the body ceases to function, but life has not ended.⁴¹ It may be possible for the pastor to interpret death to the dying child through the experience of the loss of a friend or another patient in the hospital. There are excellent suggestions as to how this may be done by the pastor and in the church school in an article by Pauline Best in The Journal of Pastoral Care. Since it essentially deals with the way death is handled in the church school, it is merely cited here for reference. The principles involved in the article, however, are valid for the pastor. Basically, the church school teacher helped children to remember the ways in which they loved a member of their class who had died the night before and to learn that those things still lived on because God continued to love the late class member even as his father and mother and his friends in the church school had continued to love him.⁴²

⁴¹See for instance Paul's letter to the Corinthians, Chapter 15.

⁴²Pauline Best, "Dealing with Death in the Church School," Journal of Pastoral Care (Spring 1948).

Edgar N. Jackson in Telling a Child About Death adds that "to deny a child a reasonable interpretation of the events he hears about as they happen is to deprive him of parental insight and reassurance when he needs it most."⁴³ He further says,

a fear of death that makes one run away from the fact is little protection against a recurring reality, so it is a poor defense. But understanding that removes fear and helps one to grow through the disappointments is a useful defense against the injury aspects of experience.⁴⁴

On the basis of these authorities, the pastor is derelict in his duty and missing a valid opportunity for ministry if he yields to the temptation to "protect" the child and does not share both factually and by interpretation with him. The need of the child is to have someone share with him about this moment which may be the loneliest in human experience. The resources of the pastor's faith and the depth of the Christian life are never more needed by the child than in this particular crisis; thus it is in response to the child's needs that the pastor makes himself and his living resources available in this ministry.

4. The anxious child. In the introduction to this paper the writer called attention to an article by Stuart McIntyre Finch entitled "Pastor's Role with the Anxious child." The article defines anxiety as a "fear of something

⁴³Jackson, op. cit., p. 13.

⁴⁴Ibid., p. 16.

inside rather than outside."⁴⁵ Finch contends that the hospital is a bigger fear for the child than for the adult because he sees it with less experience.⁴⁶ If this is true, then the pastor's ministry to all children in hospital settings will be concerned with anxiety. However, the purpose in discussing the anxious child is to delineate some of the symptomatic behavior the pastor may find which will reveal the child's needs. Freida Fromm-Reichmann's statement about anxiety is applicable to the hospitalized child.

Nearly all psychological concepts of anxiety have in common with Freud and Sullivan this one basic conception: that anxiety is tied up with the inner danger of unacceptable thoughts, feelings, wishes, or drives which elicit the expectation of loss of love and approval or of punishment.⁴⁷

Earlier in this paper the sense of rejection which the hospitalized child experiences in the separation from his family has been discussed. His anxiety level rises as he seeks to find a reason for the separation which he experiences as rejection. Here the child's fantasy and

⁴⁴Ibid., p. 15.

⁴⁵Stuart McIntyre Finch, "Pastor's Role with the Anxious Child," Pastoral Psychology, V (May 1951), 53.

⁴⁶Ibid., p. 24.

⁴⁷Freida Fromm-Reichmann "Psychiatric Aspects of Anxiety" in Maurice Stein, et. al., Identity and Anxiety: Survival of the Person in Mass Society (New York: Free Press of Glencoe, 1960), p. 131.

imagination take over, and his anxiety level rises as he points to the unacceptable feelings, thoughts, wishes, or drives within him which he expects brought the disapproval, punishment, or separation from his parents. Otto Rank, the author of Will Therapy, calls this "separation-anxiety."⁴⁸ Mrs. Fromm-Reichmann contends that the purpose of all psychotherapy is to help persons uncover unconscious reasons for the anxiety they experience.⁴⁹ This basically defines anxiety as a destructive force in the life of an individual. Schneiderman believes that anxiety has a social usefulness for the self.⁵⁰ In addition, Charles Curran has pointed out that there are three positive theological aspects of anxiety: (1) the anxious striving toward maturity, (2) the transiency of all immediate, earthly goals, and (3) the anxious longing for fulfillment in ultimate reality (God).⁵¹ O. Hobart Mowrer suggests that anxiety is a constructive force in the life of a patient, but that it is based on real guilt rather than imagined;

⁴⁸Cited in Ibid., p. 132.

⁴⁹Ibid., p. 140.

⁵⁰Leo Schneiderman, "Repression, Anxiety, and the Self" in Stein, op. cit.

⁵¹Charles Curran, "Positive Anxiety in Judaeo-Christian Thought," in Seward Hiltner and Karl Menninger Constructive Aspects of Anxiety (New York: Abingdon Press, 1963), p. 105.

and if the anxiety is not relieved, it may become a harmful experience.⁵²

However, not all anxiety is seen to be helpful and positive. Kurt Riezler,⁵³ Otto Rank,⁵⁴ and Walter J. Garre,⁵⁵ among others, see destructive effects as we noted earlier in Freida Fromm-Reichmann's position. While a definite discrepancy exists in these two views of anxiety, Rollo May in his book, The Meaning of Anxiety, has attempted to clarify this discrepancy. He distinguishes between normal anxiety and neurotic anxiety.⁵⁶ The constructive quality of anxiety seems to be what May calls normal anxiety, and the destructive element in anxiety seems to be what May calls neurotic anxiety. For the purposes of this paper the special problem of the anxious child is related to neurotic anxiety.

Normal anxiety in the child, according to May, is (1) not disproportionate to the objective threat, (2) does

⁵²See the introductions to O. Hobart Mowrer, Crises in Psychiatry and Religion (New York: Insight, 1961) and O. Herbert Mowrer, The New Group Therapy (New York: Insight, 1964).

⁵³Kurt Reizler, "The Social Psychology of Fear," in Stein, op. cit., p. 147ff.

⁵⁴Otto Rank as cited in Fromm-Reichmann, op. cit., pp. 131-132.

⁵⁵Walter J. Garre, Basic Anxiety: A New Psychological Concept (New York: Philosophical Library, 1962), p. 5ff.

⁵⁶Rollo May, The Meaning of Anxiety (New York: Ronald Press, 1950), p. 194.

not involve repression, (3) does not require neurotic defense mechanisms for its maintenance.⁵⁷ Neurotic anxiety by contrast is the opposite, requiring a disproportionate reaction to the threat, repression, and varied defense mechanisms.

A ten year old female patient who had been visited by the chaplain on several occasions demonstrated neurotic anxiety. The mother of the patient has been in a mental hospital, and the sister of the patient has also suffered from mental deficiencies, but all tests revealed that this patient was hospitalized only for her diabetic condition and that she suffered no mental deficiencies. Her room gave evidence of interest on the part of outside friends who had sent cards and toys. The responses of the child were judged to represent neurotic anxiety because she over-reacted to the possibility of a mental deficiency. She employed repression as a way of dealing with her own feelings and relating to others, and apparently used denial as a neurotic defense against her feelings and symptoms. During interviews the child exhibited much muscle tension, and the pupils of her eyes were enlarged. Both reactions seem to indicate an anxious or fearful state. Yet she denied fear and on other occasions avoided the discussion of her family, particularly her mother and her sister.

⁵⁷Ibid.

By contrast an interview with a fourteen year old adolescent in whose room no supportive signs such as cards and flowers and so forth were visible reveals a more realistic and normal display of anxiety.

- Ch 2 - How are things going with you?
 Pt 2 - I don't know.
 Ch 3 - You aren't sure why you're here?
 Pt 3 - I may have appendicitus or something else. They aren't sure.
 Ch 4 - I can see that it would make you uneasy not knowing what was wrong.
 Pt 4 - They brought me into emergency at 4 A.M. Sunday and there was a man out of his mind down there. They couldn't control him. It nearly scared me to death.
 Ch 5 - (satirically) Sounds like you had a restful night!
 Pt 5 - Yea, I got about three hours sleep. They gave me something for the pain. I feel better now.
 Ch 6 - Just a bit uncertain as to what it is, huh?
 Pt 6 - Yea. I wish I knew. The pain was here (pointing to left side) and now it's here. I don't want to talk about it.
 Ch 7 - You're afraid of the possibility of surgery?
 Pt 7 - Yes.
 Ch 8 - Surgery is frightening.

As in dealing with other problems, the pastor is constantly required to make reference to his knowledge of the emotional stages of development. Kagan and Moss have summarized the place of anxiety in the developmental life to the child in their volume Birth to Maturity: A Study in Psychological Development.

During the first four years, anxiety over anticipated loss of parental love and nurture is unusually strong and an important force in the socialization of the child. During the pre-school years anxiety becomes attached to the anticipation of physical

injury and to expression of aggressive, sexual, and dependent behavior.⁵⁸

In latency and pre-adolescence, anxiety is based on the failure to master socially valued skills, withdrawal from problems, personal inadequacy, and deviations from sex-role standards.⁵⁹ The anxiety for the teenager, as we have noted in Erikson's system, is based on identity and role diffusion conflicts.

5. The emotionally disturbed child. In the emotionally disturbed child the pastor is confronted with the greatest test of his non-verbal skills. Dr. Elaine Knutsen has pointed out "an emotionally disturbed youngster has become very keen, for his very life's sake really, in picking up the discrepancy between the word and the deed. The frequency of the discrepancy in his experience is a good part of the reason for his distrust of adults and the world. He has learned that things are other than he has been told."⁶⁰ The pastor's ministry to the child experiencing this difficulty cannot depend upon imparting knowledge about God, but must again find a relational link which will make the truth the pastor knows become a living

⁵⁸Jerome Kagan and Howard A. Moss, Birth to Maturity: A Study in Psychological Development (New York: John Wiley and Sons, 1962), p. 15.

⁵⁹Ibid., p. 17.

⁶⁰Elaine Knutsen, "The Emotionally Disturbed Child and the Religious Question," Journal of Pastoral Care, XVI:4 (Winter 1962), 198.

reality in his experience with the child. Recognizing the disturbed child may be the most difficult task the pastor faces. Howard M. Halpern says that there are four signs of emotional upset: bodily symptoms, disturbed behavior, learning difficulties, and disturbed family relationship.⁶¹ Helen Moak who says that the purpose of her book is to "help parents of emotionally disturbed children to understand both the nature of the problem with which they are confronted and the means which can be used to correct it,"⁶² lists three kinds of emotional disturbances. They are adjustment disorders--including any alteration in life such as the loss of a parent, neuroses which disable the child, and psychoses by which the child shuts out relationships. She notes also that there are two other categories sometimes used which she calls personality disorders, where the therapist works at remaking the character of the individual, and "acting out" disorders where the purpose of therapy is to control hostile, or aggressive behavior. Lydia Jackson and Kathleen Todd say that no derogatory connotation is intended in the word neurosis which includes "states of anxiety, behavior anomalies, habit disorders,

⁶¹Howard M. Halpern, A Parent's Guide to Child Psychotherapy (New York: Barnes, 1963), p. 27ff.

⁶²Helen Moak, The Troubled Child (New York: Henry Holt, 1958), p. 5.

and obsessional conditions,"⁶³ Among the factors that produce emotional disturbances these authors list (1) frequent and serious illnesses and (2) long periods of separation from the mother.⁶⁴

Other emotional traumas may bring about a disturbance in the child. The following interview with a 13 year old female demonstrates an emotional disturbance brought on by a change in the family constellation.

- Ch 1 - Hello, P. How are things with you today?
 Pt 2 - Pretty good.
 Ch 2 - I think I saw you downstairs in intensive before you were moved up here.
 Pt 3 - Yea, I got moved up here. I'm going to go home soon. That will make everybody happy!
 Ch 3 - You think people will be happy when you leave?
 Pt 4 - Yea.
 Ch 4 - It sounds as though you feel you've been a difficult patient.
 Pt 5 - Pretty bad at times.
 Ch 5 - You haven't cooperated with the nurses?
 Pt 6 - Not very well. I'm going home soon though. My grandmother will take care of me. She comes to see me every day. My father comes sometimes.
 Ch 6 - Your father doesn't come as often as you would like?
 Pt 7 - No, he comes when he can. My grandmother comes up everyday. I live with her.
 Ch 7 - What about your mother?
 Pt 8 - She comes sometimes. She's married to my uncle now. She doesn't love my Daddy anymore.
 Ch 8 - It sounds as though you find it confusing--your mother's being married to your uncle and thinking that she loved your father.
 Pt 9 - It is. I thought they loved each other. Another woman loves my Daddy. She came to the hospital to see me.

⁶³Lydia Jackson and Kathleen Todd, Child Treatment and the Therapy of Play (New York: Ronald Press, 1950), xi.

⁶⁴Ibid., pp. 89-90.

- Ch 9 - It sounds as though she likes you.
- Pt 10 - Yea, everybody has been liking me since the accident.
- Ch 10 - You were involved in an accident?
- Pt 11 - My Daddy was driving the car and then my grandmother.
- Ch 11 - You were in the car when you had the accident?
- Pt 12 - It wasn't nobody's fault. It was a dark corner with no lights. Grandma says I should go to the light next time. It wasn't nobody's fault. I was coming home from the store . . . in the crosswalk when the car hit me.
- Ch 12 - You were in the street and the car hit you?
- Pt 13 - Yes, it ran over my leg. It broke it all in one place.
- Ch 13 - It must have been a frightening experience.
- Pt 14 - My mother came to the hospital to see me. She's married to my uncle--he's 22. My mother is older.
- Ch 14 - It sounds as though your uncle is more like a brother?
- Pt 14 - Yes, he is. It seems like my mother is married to my brother rather than my uncle. He's older than me, but I act older than him. They're going to get a divorce.
- Ch 15 - You sound as though they haven't been married long.
- Pt 16 - Only a year. I don't think she loves anyone.
- (Pt has been confused and struggling with these thoughts. When other patient and a nurse who has entered begin conversation, she looks at them as though it is a signal not to talk further.)
- Ch 16 - I'm glad we had a chance to get acquainted, P. Suppose I come by again tomorrow. Perhaps we can talk again?
- Pt 17 - O.K. Goodbye.

In the chaplain's evaluation of this call the patient was seen as feeling rejected by her mother. The accident described could have been an attempted suicide (a cry for attention), and the confusion between father and grandmother as the driver of the car might indicate a feeling of rejection from the rest of the family. The interview

also indicates strong sexual feelings toward the uncle (mother's husband) which may be associated with the accident. It was felt the patient had some freedom to talk but much more time would be needed in order for this patient to ventilate her feelings and to trust enough in the relationship to grow.

In dealing with the emotional disturbances of children, the pastor comes to the essential understanding of therapy as it is defined by Clark E. Moustakas. "Relationship therapy is a growth experience created by one person seeking and needing help and another person who accepts the responsibility of offering it."⁶⁵ The pastor as the therapist with the emotionally disturbed child "waits" for the child to express himself. He makes himself available to the child in this living relationship so that the resources of his life may be useful to the child in the healing experience. "At the root of the child's difficulty is the submission and denial of his self . . . the child will fight any direct attempts to change him because such plans reject him as he is."⁶⁶ As in other problems of pastoral ministry with hospitalized children, the basic stance of the pastor is to make himself available to the

⁶⁵Clark E. Moustakas, Psychotherapy With Children: The Living Relationship (New York: Harper and Bros., 1959). p. 1.

⁶⁶Ibid., p. 3.

child and to bring the resources which the child can use in the healing relationship with the pastor. In his understanding of the child's emotional development and his comprehension of the special problems faced in pastoral ministry with the hospitalized child, the pastor becomes a sharing member of the healing team for the child.

6. The child facing surgery. The parish minister probably sees the child facing surgery as often as any other specific problem in his ministry to the hospitalized child. Richard K. Young suggests that the pastor ministers to the individual facing surgery as that person struggles with five fears: (1) the fear based on ignorance, (2) the fear based on uncertainty (the unknown), (3) the fear of adjustments following surgery, (4) the fear which results from waiting, and (5) the fear associated with anesthesia.⁶⁷ The ministry to the hospitalized child is faced with the same fears plus the magnification which the child gives to the "adult" world around him. What the pastor or another adult may intuitively know to be minor surgery, the child may exaggerate. His projections about the motivations and designs of his parents, the doctors, ministers, and the hospital staff may be grossly inaccurate, but they are real to the child. He is the person to whom we minister.

⁶⁷Young, op. cit., p. 96.

The younger the child the more apt he is to struggle because hospitalization and surgery are merely in opposition to his will. The "we" of those around him has arisen to oppose the "I" which he asserts. It is not a rational question of information and data supply plus judgment equals decision for the child. He may not understand that the surgery will be "good" for him; he may simply resist being forced to do what he does not wish to. The hostility aroused in the child may be such that the pastor's first visit will be best used to allow the child time to ventilate his feelings. Starting with the child where he is, the pastor is often able to be accepting and reassuring. As the child is able to trust more fully in those around him, he can cope more adequately with his fears.

Sometimes the pastor may share information about the surgery with the child and his parents. What the pastor says and does in this way will depend upon his own knowledge and ability, the agreement and relationship he may have with the physician, and his relationship to the child and his parents. This ministry, however, cannot be seen in isolation. The next chapter moves on to the needs of the child's family.

CHAPTER V

THE NEEDS OF THE CHILD'S FAMILY

1. THE CHILD IN THE FAMILY

If the pastor's hospital ministry to the child was done in isolation and was not affected by any other forces, this chapter would not be necessary to the paper. However, the facts are that the child is a part of a family, a society, and a world. The most significant relationships he knows are those in the family, though this does not necessarily mean that they are wholesome and health producing. The child's family relationship may be a part of, or the cause of, his emotional regression or even his hospitalization. Walter J. Garre says that "disapproval in its ultimate sense means denial of the right to exist."¹ Here is a statement of one factor in the life of the child that may have very drastic results in his later life. Garre's basic contention about anxiety is that possible emotional drain of the mother on the children for her own satisfaction may seriously affect the child's ability to perceive life and thus produce a destructive anxiety state. One example of this kind of thing is the phenomenon which

¹Walter J. Garre, Basic Anxiety: A New Psychological Concept (New York: Philosophical Library, 1962), p. 37.

is called paranoia.² In Erikson's stages of development, the writer has already noted the important role that the parents play in the life of the child.

Perhaps Virginia Satir has been the most creative and challenging family therapist of recent years. Her approach in Conjoint Family Therapy is based on the central concept that the child makes the family. That is, two married people are not a family, they are a couple. When a child is born, that couple becomes a family. Mrs. Satir's basic philosophy, as she stated it in a lecture at the School of Theology in Claremont, California, is summed up in four statements: (1) that the family members are all human beings who have more in common than they have differences, (2) that each is a unique human being, (3) that as long as life is present change is possible (there are no untreatable people and none to be seen with limited goals), (4) people are rational when one understands their premises.³ The child must be seen as a part of the unit called a family in which he participates. Stella Chess in her book, An Introduction to Child Psychiatry also stresses that in seeing the family one should not "presume" the problem. The child may annoy or be annoyed by his relationship to the rest of the family. A vicious circle of

²Ibid., p. 26.

³Virginia Satir, Claremont Lecture, March 21, 1966.

behavior which evokes parents' feelings and intensifies the child's problem may often be at the core of family difficulties.⁴ Further study of early developments may be found in other writings on the relationship of the child to the family.⁵ But the point is that a pastoral ministry to the hospitalized child cannot be effective if it is not balanced by the understanding of the child's place in his family and the effect of the family on the child.

2. THE RELATIONSHIP OF THE FAMILY

One of the concerns of pastoral ministry to hospitalized children is that the pastor helps the parents to be available to the child during the illness. If the relationship in the family is such that the child cannot draw strength from the parents or the family setting, the healing process will not be encouraged. Dr. Sherman Little of the Children's Hospital in Los Angeles suggests that therapists might assist the healing of children by forming groups of parents with similar illnesses.⁶ This suggestion may not be feasible for the pastor in the smaller parish, but might

⁴Stella Chess, An Introduction to Child Psychiatry (New York: Grune and Stratton, 1959), p. 39.

⁵See, for instance, Arnold Gesell, et. al., The First Five Years of Life (New York: Harper and Bros., 1940), 377 pages, or The Psychoanalytic Study of the Child (New York: International Universities Press, 1964).

⁶Sherman Little, "Psychotherapeutic Aspects of Chronic Illness in Children," G.P., XXXI:4 (April 1965), 132-135.

be a real possibility for the pastor in the larger church where a rotating group of parents with hospitalized children might be established.

Halpern says in the introductory chapter to his book, A Parent's Guide to Child Psychotherapy,

While this book is written for parents, it is in another sense written for children, in that it will perhaps be children in psychotherapy who will be its main benefactors. When I told one ten year old patient that I was writing this book he exclaimed, 'please send a copy to my mother'! Children desperately want their parents to know them and what they're going through. I hope this book will help to fulfill the wishes of these children.⁷

It is in this insight that we see the connection between patient-centered ministry with hospitalized children and family ministry. The child desperately needs his parents' understanding during his hospitalization, particularly in a serious illness or surgery, and the pastor's ministry to the family should help the parents make themselves available to the child.

Another difficulty in family ministry may be seen in Halpern's work. He points out that emotional disturbances rarely come on suddenly. Parents often feel that emotional disturbances reflect on them. In some cases parents unconsciously "profit" from the child's disturbance, and parents may not recognize the signs of disturbance because

⁷Howard M. Halpern, A Parent's Guide to Child Psychotherapy (New York: Barnes, 1963), p. 7.

they are unaware of them.⁸ Because the disturbances do not come on quickly and may not be recognized early, in order to minister effectively to the family, the pastor will need to be more sensitive to the family relationships. His ability to share with the family in conversation may provide the family with insight which will free them for the supportive and mature position which the child needs during his hospitalization.

Virginia Satir has suggested three other insights which are pertinent here. First, she says that parents who reinforce themselves by having the child obey them make maturity in the child a difficult process. The family lives at the price of the child. This is imbalanced relationship, however; and Mrs. Satir points out that relationship requires the price of autonomy.⁹ In evaluating the family the pastor should determine their ability to allow freedom within the relationship.

A second concern suggested by Satir is how the background of the parents affects their relationship to the children. For example, if the parents grew up in homes characterized by disagreement, it is not likely that they will be able to say, "no," or make firm requests of their

⁸Ibid., p. 27.

⁹Paraphrase of the ideas expressed by Mrs. Satir in the Claremont Lecture, March 21, 1966.

children. Love, so called, becomes a handle of control in dealing with the children. The parents develop a complicated "ought" system with which they govern the child. However, this "ought" system which moves toward sameness, against disagreement, hate, and disapproval is not realistic. Two people are bound to disagree because they are not identical with each other. The healthy family relationship will make room for these disagreements without communicating disapproval or rejection to the member who disagrees.¹⁰

The third helpful consideration is taken from Conjoint Family Therapy in which Mrs. Satir cites the studies by Dr. W. M. Brodey of five hospitalized families each with a schizophrenic member, contained in an article from the Archives of General Psychiatry. The child is often "the identified patient." The parents may not feel that they have any share in the sickness of the child, but the facts in the Brodey article indicate they do.

The striking observation was that when the parents were emotionally close, more interested in each other than either was in the patient, the patient improved. When either parent became more emotionally invested in the patient than in the other parent, the patient immediately and automatically regressed. When the parents were emotionally close, they could do no wrong in their "management" of the patient. The patient responded well to firmness, permissiveness, punishment, "talking it out," or any other "management" approach.

¹⁰Ibid.

When the parents were "emotionally divorced," any and all "management" approaches were equally unsuccessful.¹¹

The pastor's ministry to the child and to the family will be of far more ultimate value as he is able to observe and evaluate the total family relationship.

1. The parents. The third insight from Virginia Satir has already focused on the relationship of the parents to each other. Walter J. Garre also holds this to be a key factor in the development of the child: "The most important single factor in the development of the child is the emotional climate between his parents."¹² An understanding of both the physical and psychological factors in their relationship is important to the pastor's ministry with the family.

Fathers are apparently more reluctant to become involved in therapy dealing with the emotional or spiritual needs of their children if there is any implication that they may share some of the responsibility. Mrs. Satir claims that fathers are much more easily interested in conjoint family therapy.¹³ The mother is more likely to assume that if her child is labeled disturbed, she must be

¹¹Virginia Satir, Conjoint Family Therapy: A Guide to Theory and Techniques (Palo Alto, Calif.: Science and Behavior Books, 1964), pp. 4-5.

¹²Garre, op. cit., p. 34.

¹³Satir, op. cit., p. 5.

to blame.¹⁴ Garre in his discussion of anxiety points out that "the mother has the first call on the emotions of her children."¹⁵ If the mother has not gotten emotional satisfaction from her relationship to her husband, she may turn to her children to find it. Whether consciously or unconsciously, she will recognize that this is an immature satisfaction and undoubtedly will feel guilt. Eric Fromm suggests that there is a difference between a mother's love and a father's love. The motherly love is unconditional and the fatherly love is conditional. The child will form different kinds of relationships with the parents.¹⁶ Perhaps Fromm's distinction between the kinds of love a father and a mother share with their children indicates why mothers are often the first to seek help. The pastor's ministry in the hospital, it seems to this writer, is more likely to engage the family through the mother. Mothers are more likely to be at the hospital during the business hours of the day than fathers are.

Pastoral ministry to the family involves a great deal of listening and the support of simply being present. Facilitating remarks and questions by the pastor, as well as reflection, will assist the family in ventilating their

¹⁴Ibid. ¹⁵Garre, op. cit., p. 39.

¹⁶Eric Fromm as cited in Halpern, op. cit., p. 153.

feelings and dealing with guilt and fear. The following report of a pastoral visit demonstrates the use of reflection and facilitating remarks. The young mother is able to find support as she stands quietly beside the bed of her infant.

- Ch 2 - How is everything going for your little one?
 Mo 2 - He just got back from surgery. He's still whimpering a little bit. He's just three months old, and I'm afraid he doesn't understand.
 Ch 3 - It's awfully hard to communicate at that age.
 Mo 3 - It sure is. I think he's hungry, but he hasn't had anything to eat.
 Ch 4 - A tonsilectomy?
 Mo 4 - No, hernia. It all happened so quickly. I took him to the doctor yesterday morning, then to the surgeon's office; and he said why not do it today and we were here at 5:00 yesterday afternoon. The doctor said he (the baby) wouldn't know a thing and wouldn't feel it.
 Ch 5 - Sometimes these experiences seem to be more trying for parents than for the children.
 Mo 5 - They sure do. I was upset, but there was nothing I could do. He's pretty young, but he had been so fussy, I knew there must be something wrong.
 Ch 6 - I imagine it has been a difficult time for you.
 Mo 6 - Yes, but I feel better now that it's over.
 Ch 7 - At three months it doesn't seem long ago that he was born.
 Mo 7 - It sure doesn't. It has really been a fast time.
 Ch 8 - I'm glad to know that things look so good. I'm happy to have talked with you.
 Mo 8 - Thank you for stopping by, Chaplain. It was good to talk with you.

Another incident demonstrates the pastor's supportive ministry with a mother, but adds an interpreted level to the reflection.

- Ch 3 - I guess you're anxious to be getting Donna home.
 Mo 3 - (hesitantly) Yes.

- Ch 4 - You don't sound too enthusiastic about it. You appear apprehensive.
- Mo 4 - Yes, I am. It'll be nice to have her home but it's a big responsibility.
- Ther 2 - You'll be able to handle it, won't you?
- Mo 5 - Oh, I'm sure I will. I know how to give the shots (pause). It's just the whole idea of taking care of her . . . the fear of doing something wrong. I really don't want to talk about it. Every time I do, I cry. (bursting into tears and going over to the other side of the room to the basin)
- Ch 5 - This has been a big strain, hasn't it?
- Mo 6 - Yes . . . I should be more adult about it . . . shouldn't cry, but I'm feeling a little sorry for myself. But it's so hard.
- Ch 6 - You feel it's too much responsibility for you to bear?
- Mo 7 - I know I should be able to take care of all these responsibilities, but I have to do it so much of the time alone. He tells me all I have to do is talk to him, but it goes in one ear and out the other. He's gone so much of the time . . . It's all so hard for me . . . Some people have it so easy. They don't deserve it. Other people . . . everything goes wrong for them.
- Ch 7 - You feel that life is throwing you a curve?
- Mo 8 - Yes, I've felt that way for about ten years now. I'm the kind of a person that should have gotten married, but not had children. I told you this morning that I don't like to babysit except in an emergency for my sister.
- Ch 8 - Children are a real responsibility for you?
- Mo 9 - Well, my husband doesn't help me with them. He's always gone and leaves me alone to take care of them.
- Ch 9 - You feel that your husband doesn't share the burden with you? You have to do it all alone?
- Mo 10 - Yes, that's right. We should not have had children. We got married and started on the wrong foot.
- Ch 10 - You have other children than Donna?
- Mo 11 - Yes, three altogether. It's rush here and rush there. Do this and do that. I wish I could go someplace without having to prepare for a baby!
- Ch 11 - It seems to me that you're saying that children are some sort of punishment.
- Mo 12 - Maybe they are. Some friends have told me that I ought to go to church, but I haven't gone. Maybe I should go.

- Ch 12 - Do you think going to church would help you with this?
- Mo 13 - Well, it might. I ought to give it a try anyway.
- Ch 13 - I'm sure you can find some help for your problem.
- Mo 14 - I'll be all right later, as soon as I'm adjusted to it. It's just all so hard to take right now . . . Thank you for listening to me.
- Ch 14 - I appreciate your confidence in sharing these with me.

These incidents from the clinical training experience of the writer indicate the kind of supportive role the pastor may play with the mother as she spends anxious hours beside the bed of her hospitalized child.

2. The siblings. The place in the relationship of the other children in the family will also be a part of the pastor's concern in evaluating the family relationship. An incident with the mother of an eight year old illustrated her fear of the relationship of her older sibling children to the hospitalized child. The child had had an operation to correct the opening of the eye lid, and the mother was relieved that her child would no longer be called "the little girl with one big eye and one little eye."

The illness of the hospitalized child may not always be understood by the sibling. He may even feel that he is to blame for the illness. The older sibling may have felt jealousy toward a younger child, even to dreaming or wishing for the death of the child. When the younger child then becomes hospitalized, the older child may develop a great deal of neurotic guilt, not founded on fact.

This neurotic guilt may create an anxiety-stage in the older sibling child. This mental state is not in proportion to the reality of the situation. Repression becomes the way of dealing with his feelings, and his defense mechanisms are disproportionate. The hospitalized child may also misbehave because his basic security is threatened. The factors most commonly cited in behavior difficulties are sibling jealousy, parental rejection, and overprotection.¹⁷

As the parents reveal their way of relating to the children, the pastor observes the way the family solves its own problems. Walter A. Garre suggests that "the simplest form of therapy is repressive."¹⁸ The family may use this solution as a way of dealing with its problems. The parent tells the patient that he shares the problem with others, thus suggesting that he repress his own fears and guilt feelings about it. Garre's contention is that the patient will try all therapists to find if other human beings are as inadequate as were the significant persons in his own life.¹⁹ "The real objection to repression is that it is a crude and primitive method of dealing with inner conflicts, and should as soon as possible, be replaced by the method

¹⁷Lawrence D. Slobody, Survey of Current Critical Pediatrics (New York: McGraw-Hill, 1963), p. 54.

¹⁸Garre, op. cit., p. 55.

¹⁹Ibid., p. 59.

of conscious and deliberate control."²⁰ It is in recognizing repression by the parents, the hospitalized child, or the siblings that the pastor is able to use his therapeutic skills to teach the family a different, and better way, of handling conflicts. Sharpening the pastor's skills in recognizing and therapeutically handling the relationship of the family is a prime concern.

Dr. Leo Kanner has listed six principles of orientation to pediatric work within the medical community which by application are helpful to the pastoral ministry. He says: (1) coercion intended as a prophylaxis does not prevent. That is, rules do not prevent problems. (2) The nuisance value of a child's problematic behavior depends on the threshold of annoyance and anxiety of the people around the child, (3) this threshold of annoyance depends more on attitudes of people than absolute values assigned to the symptoms, (4) the attitudes of adults should not be dismissed with adjectives because they represent emotional problems and should be approached as such, (5) semantic confusion around "spoiling" and "disciplining" should be clarified, and (6) attitudes rather than individual acts count in parent-child relations.²¹

²⁰Lydia Jackson and Kathleen Todd, Child Treatment and the Therapy of Play (New York: Ronald Press, 1950), p. 18.

²¹Leo Kanner, Jr. in Helen Witmer, Editor, Pediatrics and the Emotional Needs of the Child (Cambridge: Harvard University Press, 1948), p. 100ff.

These six principles also apply to the pastoral care of hospitalized children and their families. For the pastor as well as the physician, rules don't prevent problems or problematic behavior from developing. For instance, the pastor may say in a Biblical admonition, "Fear not . . . ;" but that does not keep the child or the family from fearing. He may tell the siblings whose brother or sister is in the hospital not to be afraid, but that is simply inviting the child to repress his feelings and to turn his back on reality, if he actually is afraid. The threshold of annoyance and anxiety is discovered in observing the parents, nurses, and siblings. The parents may verbally claim that little value is associated with certain actions on the part of the siblings, but their anxiety and disturbance may indicate that their attitudes differ from their verbal evaluation. The pastor may also be tempted as Kanner indicates to say that a parent is anxious or upset rather than to take seriously the feelings and problems with which the parent is confronted. The parent may feel that his attitudes are unimportant if the pastor does not respond in a supportive way to their needs as well as those of the siblings. The discrepancy between the family's description of their relationship and the actual relationship may be revealing. Satir and others have pointed out that "love" behind what we call spoiling the child may actually be a very controlling device. Discipline on the

other hand may be a very hostile form of relating to one's child. The sibling may be very important to an adequate picture of the family because of his special significance when another child in the family is hospitalized. The parents may feel guilty about their relationship to the children and seek expiation in their actions toward the sick child while they may continue to exhibit hostile and aggressive behavior toward the child that is well. This is a matter that deserves significant research, but it is not central enough to this paper to require more than these cursory comments here.

3. Other significant persons. Virginia Satir has pointed out that the family is affected by other persons who live with them, whether relatives or not. The family setting may include another relative such as a grandparent.²² Understanding the parents of the hospitalized child, to whom he is called to minister, may be a difficult task if the pastor is not aware that they are in constant contact with one of their own parents. Every person related to the family should be considered in helping the family deal with the more serious incidents of hospitalization. If there is evidence of emotional disturbance, the "other" person in the family such as the grandparent, may become the scapegoat.

²²Satir, op. cit., pp. 106-107.

Helen Moak in the Troubled Child suggests that a grandparent may play an important part in the life of the child.

A sympathetic ear to whom a child can pour out his troubles, a loving heart (and the time to show it) that makes a child feel always welcome, a relationship that is different from that of the parents but is yet mature--these are the special things that grandparents can give a child.²³

Grandparents may play both a detrimental and a beneficial role. The principle of being aware of the presence of another significant person affecting the family constellation is the important thing for the pastor's ministry with the family of the child.

How the family may be ministered to in the serious crisis, such as the death of the child, is the next consideration which seems appropriate.

3. THE DEATH IN THE FAMILY

Facing death, particularly the death of a child, is one of the most difficult tasks of the pastoral ministry. Yet it may be one of the most significant privileges the minister has and perhaps his greatest opportunity for therapeutic ministry. This writer's introduction to the clinical training experience, alluded to in the introduction to this paper, was with the parents of a dying infant. The

²³Helen Moak, The Troubled Child (New York: Henry Holt, 1958), p. 62.

call came for the baptism of the child. The parents of the infant were of Lutheran background, but the writer is a Baptist. Here is where one begins to make the kind of decisions that become necessary in his ministry to the family. Is it more important to meet the family's need than to uphold his theological heritage? A pastor from an immersionist background must decide whether it is more important for him to maintain what he considers to be a position supported by scripture or to perform a ceremony--whether he believes it to be a sacrament or not--for the sake of supportive ministry with the parents. This writer chose the latter course.

Ch 1 - Hello.

Fa 1 - I'm Don Adams. Thanks for coming. (wife smiled tearfully.)

Ch 2 - (hearing request of nurse to ask parents to leave while she did blood tests) We'll need to wait about fifteen minutes for this procedure, would you like to sit in the solarium?

Wife 1 - Yes, please (walking toward door)

After entering solarium with permission of receptionist, we sat in silence for several moments. Father was on the verge of tears, wife weeping quietly.

Ch 3 - Would you like to share a few moments of quiet prayer?

Wife 2 - Yes, please.

Fa 2 - Yes, we would.

Ch 4 - Our Father, be with these parents in these moments of suffering (long pause) Thou knowest their suffering because Thou hast seen Thy Son suffer. Give them grace and strength for this difficult time. Through Jesus Christ our Lord and in His Spirit we pray. Amen.

Wife 3 - Thank you. (several moments of silence--wife leaves to go to rest room.)

Fa 3 - I'm optimistic. I think they'll pull him through.

Ch 5 - I'm sure they'll do everything possible.

- Fa 4 - If they can just keep him strong enough for that surgery.
- Ch 6 - They hope to do open heart?
- Fa 5 - It will be one of three problems--all of which will require open heart. They can do wonderful things these days.
- Ch 7 - We recently had a family with a 36-hour-old child who had open heart surgery successfully . . . it's a year old and quite healthy now. (wife re-enters room. We all sit quietly for more moments.)
- Ch 8 - (sensing impatience) I'll check to see if they're ready for us. (leaves room and parents) (Returns to get parents and takes them to the room)
- Ch 9 - (to Doctor) I'm Chaplain Kilgore. May we proceed with the service of baptism?
- Do 1 - I'm Doctor Schearing. Glad to meet you Chaplain. Go right ahead (he leaves room)
- Ch 10 - Did you say that the child's name is Brian?
- Fa 6 - Yes, that's right.
- Ch 11 - Jesus said, "Suffer the little children to come to me and forbid them not; for of such is the kingdom of heaven." Brian Adams, upon the request of your parents I baptize you in the name of the Father, the Son, and the Holy Spirit. Amen. (prayer) Father, the spirit of this child is thine. Bless him now and through eternity. Through Jesus Christ our Lord. Amen.
- Fa 7 - Thank you.
- Mo 4 - Thank you, Chaplain. (leaving room together, walking to waiting area on fourth floor)
- Ch 12 - I'll be downstairs in the chaplain's office if you wish to talk or if I can be of further help. I'll check in a little while to see how Brian's doing.
- Fa 8 - Thank you.

The interview reveals the reassuring quality of pastoral ministry. The pastor empathizes with the parents, assures them of his confidence in the medical effort being made on behalf of the child, and uses the scripture as a resource of promise and hope. But the pastor does not promise that the child will live. In facing death with the parents or

the family, the pastor is tempted to assure the family of more than he actually has experienced or can know. The pastor's own fear of adequacy are present in this situation. One wonders if it is not better to share honestly one's own feeling of the unknown factor in death, and thus allow the parents to know that the pastor experiences the same human emotion they do.

In the article cited earlier by Vernick and Karon about the reaction of children in a leukemia ward at the National Cancer Institute, the hypothesis of the authors is that doctors do not talk about death because they are (1) oriented to cure and (2) not immune to their own feelings about death.²⁴ This same hypothesis could be suggested in terms of the pastor's failure to discuss death with the family. Gardiner Murphy suggests there are seven fears of death:

(1) Fear that death is the end (2) fear of losing consciousness (3) fear of loneliness (4) fear of the unknown (5) fear of punishment (6) fear of what happens to one's dependents (7) fear of failure.²⁵

Acknowledging these fears will open the way for the family to be more mature and honest to share their feelings as they face the death of one they love.

²⁴Op. cit., p. 393.

²⁵Gardiner Murphy in Herman Fiefel, The Meaning of Death (New York: McGraw-Hill, 1959).

The goal for the pastor or the family, however, is not just a rational understanding of humanity and finitude. Nor is the goal of pastoral ministry to deal with the theology of death. There may be occasions when the pastor has the opportunity to deal with theological insights related to dying. The feelings of the parents, the reassurance they need and the ability to make one's self available to the dying child are the key concerns in facing death. Parents may remain frustrated if there is no opportunity for the ventilation of their feelings about the child's dying. The following interview with a mother of a hospitalized child reveals that her feelings about the loss of a baby a year earlier had not yet been fully worked out.

Ch 1 - Hello, I'm one of the ministers here at the hospital. I don't believe I met your child yesterday when I was around. How are things going?

Mo 1 - They are just now bringing her back from surgery on her hip.

Ch 2 - It appears as if this has been a difficult experience for you (sitting down)

Mo 2 - It really has (tears starting to come). I lost a baby about a year ago and now this with Nita. She's so young to have to lie there in bed and suffer.

Ch 3 - How old is she?

Mo 3 - Six, but she's real active and I imagine it's going to be rough--I guess I'm expecting the worst.

Ch 4 - Have the doctors indicated something to cause your doubt?

Mo 4 - No, I guess it's just natural to expect the worst.

Ch 5 - You seem to be reminded of the death of your other child.

- Mo 5 - I am. I still can't be around babies--she was two months old. I had trouble carrying her and when she was born, they said she was perfect, and then she died of instant pneumonia. The doctors said we did everything we could for her, and the pastor said she was better off. God must have His reasons.
- Ch 6 - Do you feel God punished you in the death of the child?
- Mo 6 - No, he gave her and took her, and I understand that life's like that, but . . .
- Ch 7 - (pause) Sometimes understanding doesn't take away our feelings.
- Mo 7 - No, it doesn't. I just feel like I've come as far as I can go. You can only take so much.
- Ch 8 - Everything seems to be on the raw edge?
- Mo 8 - Yes. (pause) (looking at her watch) They said she would be right up to her room and that was thirty-five minutes ago. Her blood pressure dropped, they had to give her blood, I wonder if they have had complications.
- Ch 9 - I'll be happy to go down to see if I can find out what's holding her up. (pause) Would it be helpful if we had a moment of prayer before I go?
- Mo 9 - Please do.
- Ch 10 - Father, we know that we do not understand all of life. We thank Thee for the faith to believe that Thou dost love us. Be with Nita and her mother during this difficult time. Comfort them and strengthen them we pray. Bless the other members of the family too. In Jesus name. Amen. I'll be back in a moment when I know something of your daughter's condition.

Two kinds of ministry are shown in this interview. The pastor empathizes with the mother, reflects, and seeks to give her an opportunity to ventilate repressed feelings about the death of her child. The pastor also seeks to gain information about the condition of the presently hospitalized child and reassures the mother with the report. In facing death, the family needs not only the support of the pastor in reassurance and empathy, but the members of

the family also need adequate information which will help them in resolving their feelings.

The parents' feelings are discussed in an article by Howard Williams, "On a Teaching Hospital's Responsibility to Counsel Parents Concerning Their Child's Death." The author emphasizes three areas of concern: (1) unless problems are discussed, parents are not satisfied and confidence is lost; (2) parents, particularly mothers, feel most guilty and a rational explanation helps relieve guilt; and (3) the parents often carry the fear of future pregnancies due to the disappointment resulting from anticipation of the child and the shock of having produced "an abnormal baby."²⁶ Again the medical field has produced an insight which is needed in pastoral ministry to the family. If the pastor does not discuss the problems surrounding the child's death with maturity and honesty, the family's confidence in him is also disturbed. The suggestions of an autopsy is one way in which the pastor can help to relieve the false guilt of parents in the death of their children. Assurance, where it is not contrary to known medical facts, that the parents may have another child and encouragement for them to do so as they feel ready would be a very

²⁶Howard Williams, "On a Teaching Hospital's Responsibility to Counsel Parents Concerning Their Child's Death," Medical Journal of Australia, II:16 (October 19, 1963), 643-645.

supportive role that the pastor may play following the death of the child. The pastor needs to be both factual and interpretative, even as he handles the subject of death with children. (See earlier discussion of the dying child)²⁷ In much the same way the pastor will deal with the sibling children in the family, depending on the ages of the children and their ability to comprehend death. This emotional, maturational ability to receive information about death has been discussed earlier, and it does not seem necessary to repeat or add to that at this point.

²⁷Particularly see Helen H. and Louis J. Sherrill, "Interpreting Death to Children," International Journal of Religious Education, XXVIII (October 1951), 4-6.

CHAPTER VI

SUMMARY

The writer's purpose has been to explore the relationship of the pastor to the hospitalized child and his family. The needs of the hospitalized child have been examined in light of the stages of development outlined by Erik Erikson.¹ The exceptions and special problems have been explored in dealing with the retarded child, the physically handicapped child, the critically ill or dying child, the anxious child, the emotionally disturbed child, and the child facing surgery.

The needs of the child's family have been examined, using the basic approach represented by Virginia Satir,² giving special attention to the crisis presented in the death of a child.

The needs of the pastor have been explored, including his presuppositions about childhood, his childlike qualities,³ his own crisis feelings, and his relation to

¹Erik H. Erikson, Childhood in Society (New York: Norton, 1950).

²Virginia Satir, Conjoint Family Therapy (Palo Alto, Calif.: Science and Behaviour Books, 1960).

³Eric Berne, Transactional Analysis in Psychotherapy (New York: Grove Press, 1961).

his own children. The question of pastoral ability with children and, how to evaluate it, has been examined.

Finally, the pastor's preparation for this ministry, his goals, his resources, and the principles which are behind his practice of ministry with the hospitalized child have been examined.

In so doing, the writer has demonstrated that the pastor is a valuable asset on the healing team, providing for the child and his family during this kind of crisis experiences a ministry necessary in the healing process. One of the writer's remaining hopes is to continue research and practical experimentation with the use of religious resources both in the hospital ministry and in the parish ministry with children. In this way he can continue to shape his underlying principles and concepts of pastoral values. The statement of principles and concepts at this point is workable and satisfactory for the present experience of the writer, but it is his hope and desire that these principles will change and that his ability to explicate them will increase with future and more extensive opportunities of pastoral ministry to the hospitalized child.

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